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JANUARY 1998

SCIENTIFIC ARTICLES

Gynecomastia: A Clinical Experience

Mathematical Models to Correlate Amniotic Fluid Index and Amniotic Fluid Volume

SPECIAL ARTICLE

Addressing the Problem of Medical Malpractice

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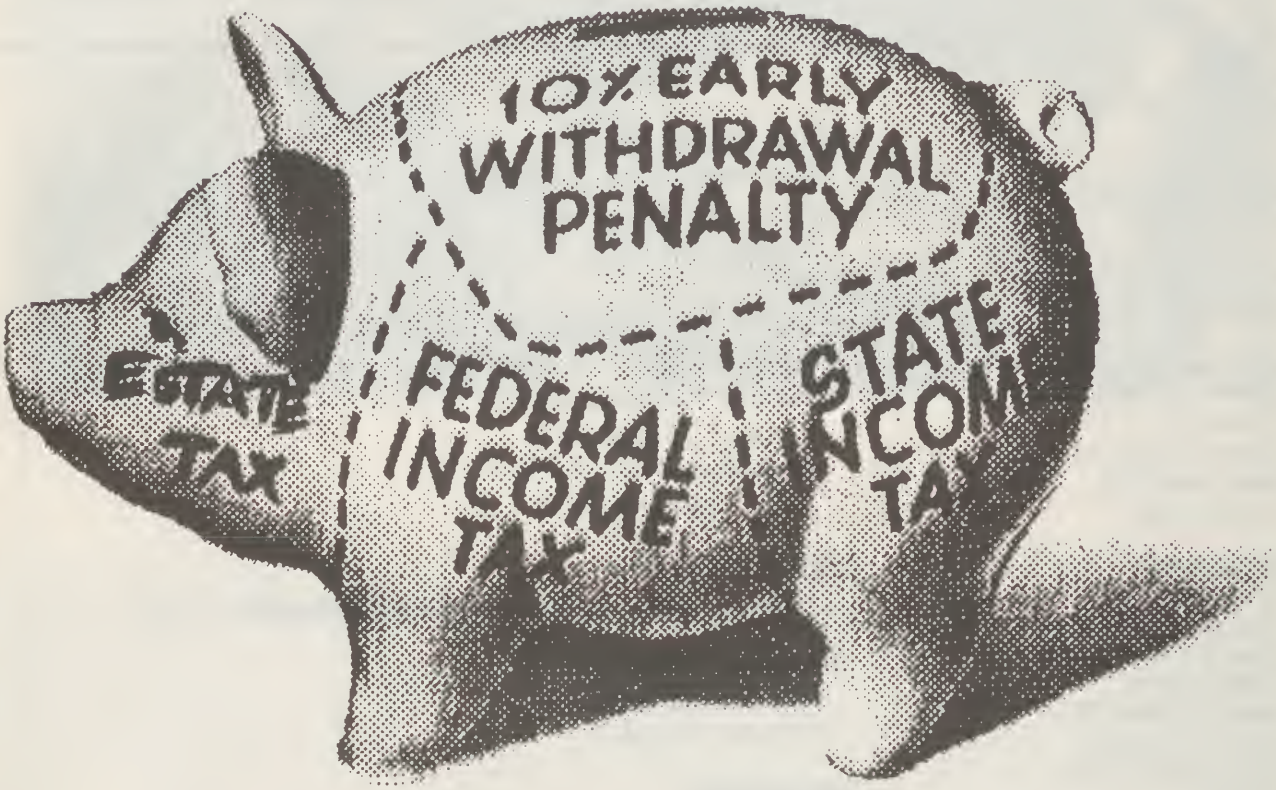
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Gynecomastia: A Clinical Experience

Robert D. Holbert, M.D.
Stephen J. Nunenmacher, M.D.

ABSTRACT

The purpose of this manuscript is to describe a one year experience with Gynecomastia. The patients studied were men who came to the clinic with breast enlargement. The clinical experience appeared to reflect an unexpected number of patients with this diagnosis. The result revealed thirty percent of this group had potentially progressive underlying causes of Gynecomastia.[9]

INTRODUCTION

Gynecomastia usually refers to a benign enlargement of the male breast. A normal occurrence of puberty, it is seen in 60% to 70% of that population.[1,8] It also can be found in up to 60% of men starting in their seventh decade. There are many factors that play a role in the development of gynecomastia; some of these are medications, illicit drugs, estrogen/androgen ratio, sex hormone binding globulin levels, age, and various genetic defects. There are many different pathways to reach an endpoint in which estrogen influence in the male breast becomes more dominant.[1,2,3]

Over the past fifteen years we have evaluated patients in our practice with gynecomastia. We have generally seen one patient with gynecomastia every two years. During the past 12 months we have seen 10 patients with gynecomastia. We found this to be a striking change in the local pattern of this condition in our practice. Each patient with gynecomastia was evaluated with a standard group of studies to include history, physical exam, radiologic exams, and laboratory tests. We have presented a summary of our findings in this report.

DISCUSSION

Gynecomastia is a very common condition. It is found in up to 70% of pubertal males, as well as 60 % of adult males, especially the older patients.[8] The process is usually benign and often self-limited. If the process is painful, socially significant, emotionally significant, or unusual, it should be investigated. The most effective treatment is surgical reduction.

The examination of the male breast includes techniques to feel for a mass with glandular characteristics. It may be best to elevate the subareolar tissue between the thumb and forefinger and rotate the tissue between the fingers. Obesity makes the exam more difficult.[8]

The male breast tissue is identical to the female in the newborn. At puberty hormonal stimulation makes the male tissues respond differently from the female. The male breast can respond to many changes later in life that cause glandular tissue to develop. In general, it is understood that the final process in gynecomastia is increased estrogen effect on the dormant breast tissue due to a change in the estrogen/testosterone ratio.[6] There are multiple causes: endocrine disorder, such as pituitary, adrenal, thyroid, and testicular abnormalities; many prescription drugs, many illicit drugs, nutritional supplements (saw palmetto); and alcohol.[1,2,3,9] The lists of drugs (both illicit and prescription), and nutritional supplements continue to enlarge as clinical observation reveal more side effects.[1,2,3,5,7]

FIGURE #1

MEDICATIONS:

Spironolactone	Cimetidine	Periactin
Flutamide	Finasteride	Saw Palmetto
Marijuana	Digitalis	Chemotherapy
Estrogen	Methyldopa	Reserpine
Tricyclic Antidepressants		

Figure #1 is a list of drugs which can be associated with Gynecomastia.

There is another diagnostic consideration regarding enlarged breast tissue, that being primary breast cancer. This is an unusual diagnosis of men, occurring in 900 patients each year in the United States. Breast cancer should be considered when breast enlargement is unilateral, eccentric, and/or involving skin ulceration.[4,5]

CONCLUSION

We noted a marked increase in the number of patients with symptomatic gynecomastia. We did not recognize a feature in these patients which would have led us to make a diagnosis of an endocrine tie disorder without the benefit of a laboratory evaluation. Each patient presented with a principal complaint of a swollen breast. Except in the pubertal patients, the physical exam was not diagnostic by itself. History, physical examination, laboratory and radiologic studies all played an important role in our evaluation. Three patients out of ten had a disease which could have become very serious over time. These patients were discovered to have a more complex disease because of our laboratory and radiologic evaluation. Due to the high percentage of serious diagnoses in this extremely small group, it seems that the use of laboratory and radiologic evaluations is cost-effective.

TABLE 1

	ELECTROLYTE		EST	TES	PROLACTN	LH	ACTH	FSH	HCG
#1									
#2	138	103	33	451	12	5.1	34	3.4	NEG
	4.2	21							
#3	143	106	34		4	3.8	n/a	3.6	NEG
	4.2	26		n/a					
#4	141	103	38	440	11	5.7	40	5.2	NEG
	3.5	28							
#5	140	108	86	293	5	3.7	LESS 5	2.9	NEG
	3.8	24							
#6	140	106	26	194	33	7.7	44	8.1	NEG
	3.8	28							
#7	135	101	27	470	12	7.4	15	7.4	NEG
	3.7	22							
#8	135	98	98	341	4	5	113	3.7	NEG
	4.7	27							
#9	139	98	31	434	7	5.2	39	4.7	NEG
	4.1	26							
#10	142	103	21	434	3	5.0	23	6.7	NEG
	4.4	28							

Table number 1 represent much of the laboratory evaluation preformed on the patients with gynecomastia, the major portion of the studies well within normal laboratory range with the exception of patients numbers 5, 6, and 8. Patient number five manifested a low ACTH while patient number six manifested a low testosterone and slight elevation of the prolactin. Patient number eight had an elevated ACTH.

TABLE 2

	GENERAL BODY HABITUS	BP	BREAST EXAM	TESTICULAR EXAM
#1	NORMAL	120/70	GYNECOMASTIA	NORMAL
#2	OBESE	130/96	GYNECOMASTIA	NORMAL
#3	NORMAL	150/90	RT BREAST MASS	NORMAL
#4	NORMAL	132/80	GYNECOMASTIA	NORMAL
#5	OBESE	180/110	GYNECOMASTIA	NORMAL
#6	NORMAL	125/84	GYNECOMASTIA	NORMAL
#7	NORMAL	120/70	GYNECOMASTIA	NORMAL
#8	OBESE	170/80	GYNECOMASTIA	NORMAL
#9	NORMAL	122/80	GYNECOMASTIA	NORMAL
#10	OBESE	138/98	GYNECOMASTIA	NORMAL

TABLE #2 describes some of the physical findings of this group of patients. Three of the patients had hypertension otherwise there were no distinguishing characteristics.

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TABLE 3

#1	Dx. Normal Pubertal male
#2	Hypertension, Hyperlipidemia, Obesity, Gynecomastia, Renal Insufficiency MEDS: Maxide, Yohimbine, Monopril, Lopressor, Provacol
#3	Hypertension, Hyperlipidemia, Seizure MEDS: Dilantin, Minipres
#4	Prostatitis, Hyperlipidemia, Spastic Colon, Lumbar Disc Disease MEDS: Kdur, K phos, Librax, Proscar, Hytrin, Ultram, Robaxin
#5	Hypertension, Obesity, COPD, Allergy MEDS: Prozac, Hytrin, Vasotec, Xanax, Lopressor
#6	Skin Infection, Lymphedema, Hyperlipidemia MEDS: Parlodel
#7	Hypertension, Gall Stones, Osteoarthritis MEDS: Calan, Darvon, Vasotec
#8	Hypertension, Obesity MEDS: Prinivil
#9	Gynecomastia with subcutaneous mastectomy MEDS: None
#10	Hypertension, CAD, Abnormal LFT, Hemoglobinopathy MEDS: Vasotec, Toprol

Table 3 lists the diagnosis and medication of each of the patients in the group.

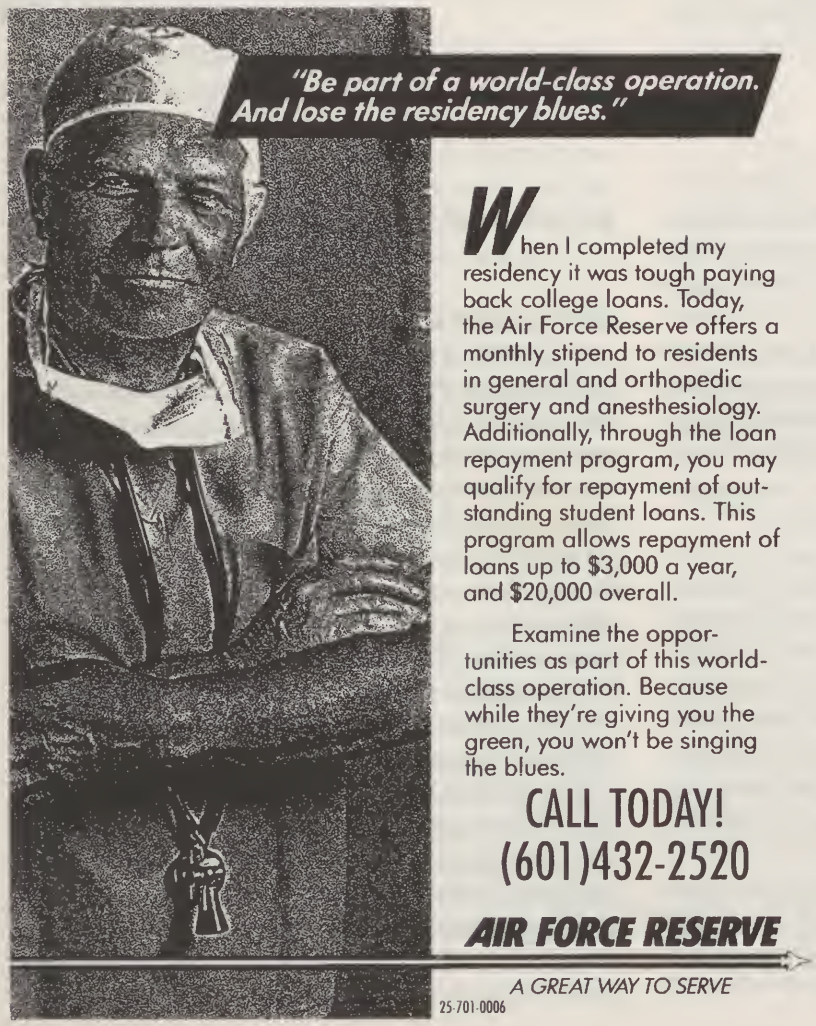
TABLE 4

	OUTCOME
#1	Normal Male - regressed
#2	Idiopathic Gynecomastia - renal failure
#3	Gynecomastia with Breast Abscess - non-malignant; no further treatment
#4	Idiopathic Gynecomastia - age related - surgical removal
#5	Gynecomastia due to Famial Adrenal Hyperplasia - regressed
#6	Gynecomastia due to Microadenoma of the pituitary gland. Hypogonadism symptoms cleared with meds.
#7	Idiopathic Gynecomastia; age-related; benign nodule in right breast - regressed
#8	Gynecomastia, not biopsied -observation
#9	Idiopathic Gynecomastia, probable Cushing - refused further evaluation
#10	Idiopathic Gynecomastia, not Biopsied - preferred no treatment

Table 4 represent the final diagnosis of each of the patients in the group. Three of the patients had a significant diagnosis.

***Dr. Holbert** and **Dr. Nunenmacher** are Internal Medicine physicians whose office is Gautier Medical Clinic in Gautier, Mississippi, USA. The clinic is a community outreach program of Biloxi Regional Medical Center.*

Reprints will not be available.



Mathematical Models to Correlate Amniotic Fluid Index and Amniotic Fluid Volume

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Everett F. Magann, M.D.
Bryan D. Cowan, M.D.
Kenneth G. Perry, Jr., M.D.
John C. Morrison, M.D.

ABSTRACT

Purpose: To describe a predictable relationship that relates amniotic fluid index (AFI) to amniotic fluid volume (AFV) and improve the accuracy of AFI to detect true oligohydramnios.

Methods: Data from 42 parturients (group I) who underwent measurements of amniotic fluid sonographically (amniotic fluid index) as well as by dye-dilution technique was used to relate AFI to AFV. Subsequently, 22 consecutive women (group II) were used to test the accuracy of the equation to predict true oligohydramnios.

Results: In group II, 11 of 22 patients had true oligohydramnios and the sensitivity, specificity, positive and negative predictive values of AFI $\leq$ 5.0 to detect a confirmed AFV < 500 mL were 0%, 91%, 0%, and 48%, respectively. These values of AFI, when used in conjunction with the equation, improved to 73%, 55%, 62%, 67%, respectively. With AFI and the equation, significantly more patients in group II with true oligohydramnios (8 of 11) could be detected than with using AFI alone (0 of 11; $p = 0.002$).

Conclusion: AFI is poor predictor of true oligohydramnios. Using the mathematical model, the detection rate of oligohydramnios is significantly improved.

KEY WORDS: Amniotic Fluid Volume, Amniotic Fluid Index

INTRODUCTION

Abnormal amounts of the amniotic fluid are associated with structural and chromosomal abnormalities, which are accompanied by a high perinatal mortality and morbidity.[1-5] There are two methods of determining the amniotic fluid volume (AFV) and each have their advantages and disadvantages. The dye-dilution method to determine the actual AFV, although accurate, is invasive, time consuming, and cumbersome.[6-8] Sonographic measurement of amniotic fluid, as described by Phelan and coworkers,[9] is simple and clinically practical,[10-14] but it does not assess the actual amount of AFV.[8,15] Recently, Magann and coworkers,[8] noted that amniotic fluid index (AFI) $\leq$ 5.0 cm was a very poor predictor (sensitivity of 6.7%), of true oligohydramnios, defined as AFV < 500 mL.[8,15] The purpose of this study was to assess if with mathematical models, one can correlate AFI with true amniotic volume and improve the detection rate of true oligohydramnios.

MATERIAL AND METHODS

This prospective study consisted of 64 consecutive parturients who underwent an amniocentesis in the third trimester to assess fetal lung maturity or to detect subclinical chorioamnionitis. Group I consisted of the first 42 patients and group II comprised of the next 22 patients--all of whom had an AFI and determination of the amniotic volume using dye dilution technique. The first group was used to derive the mathematical models correlating the AFI with amniotic volume while the second group of patients was used to assess the accuracy of predicting oligohydramnios using the newly generated equation. Forty of the 42 patients in the first group were included in our earlier report.[8]

The inclusion criteria were nonlaboring, singleton pregnancy at 28 to 37 weeks' gestation, with no known fetal anomalies and intact membranes. The exclusion criteria were maternal age < 15 years, gestational age < 28 weeks, or inability to give informed consent. All participants signed a consent form which was approved by the Investigational Review Board of the University of Mississippi Medical Center.

All of the ultrasonographic examinations were performed by the same examiner (EFM) to avoid interobserver variability using an Ultramark-IV device (Advanced Technology Laboratories, Bothell, WA). With the patient in the supine position, AFI was measured as described by Phelan and coworkers.[9] An AFI $\leq$ 5.0 cm was considered oligohydramnios, while a measurement > 18 cm is hydramnios.

The amniocentesis was performed after the sonographic examination. After the amniotic fluid was obtained for clinical studies, 2 ml of 20% aqueous solution of aminohippurate sodium (400 mg, Merck, West Point, PA) was injected into the amniotic cavity. Continuous ultrasonographic examination was performed during the procedure to assess the relative position of the fetus and the amniocentesis needle which was left in the place. To promote rapid mixing of the aminohippurate sodium with the amniotic fluid, the plunger of the syringe was withdrawn and depressed several times. At the end of 20 to 30 minutes, 3 mm of the amniotic fluid was collected and stored at -20° C.

The aminohippurate sodium concentrations and AFVs were determined with the diazo dye-reaction and spectrophometric techniques of Charles and Jacoby.[6] The intraassay and interassay coefficient of variation was 1.9% and 3.5%, respectively. Serial dilutions of the samples yielded aminohippurate sodium concentrations that were 101.8% of the expected value, and the dye added to a pool of amniotic fluid was recovered at a rate of 110%.

Among the 42 patients in group I, several regression analysis were performed to assess the correlation between AFI versus AFV, as determined by the dye-dilution technique. The purpose of these equations was not only to improve the accuracy of an AFI to detect oligohydramnios but also to estimate the actual AFV for a given AFI. To obtain the best relationship between AFV and AFI, linear and polynomial regression equation up to fourth-degree were tested. The equation which had the highest accuracy of predicting true oligohydramnios and had the lowest mean percent error in predicting the actual volume was selected. Percent error was defined as:

$$\frac{\text{predicted amniotic fluid volume - actual amniotic fluid volume}}{\text{actual amniotic fluid volume}} * 100$$

The data was analyzed by chi square or Fisher exact test where appropriate. A value of $P < 0.05$ was considered statistically significant. Test efficiency, sensitivity, specificity, and positive and negative predictive values of AFI $\leq$ 5.0 cm or of predicted AFV to detect true oligohydramnios (AFV < 500 mL, by dye dilution technique) was calculated.

RESULTS

Table 1 lists the AFV as determined by dye-dilution technique and the AFI for both groups. The range of AFV for group I was 160 to 3900 mL while it was 212 to 5579 mL for the second group. The range of AFI for group I and II were 2.1 to 30.0 cm and 4.6 to 23.9 cm, respectively. Overall, among the 64 patients the mean ($\pm$ SD) AFV was 879 $\pm$ 909 mL and the mean AFI was 13.6 $\pm$ 6.4 cm.

The regression equation (equation 1) with the highest accuracy in detecting oligohydramnios is:

$$AFV = \text{absolute value}\left(574.891 - 207.655 * AFI + 38.5744 * AFI^2 - 2.11748 * AFI^3\right)$$

where AFV is amniotic fluid volume and AFI is amniotic fluid index. The R^2 for this relationship is 75% with a $P < 0.05$ for all the coefficients. In group II, there were 11 patients who had an AFV < 500 mL, and AFI $\leq$ 5.0 cm alone did not identify any of the patients as having oligohydramnios. Using the AFI and regression equation, significantly more patients (8/11; $P = 0.002$) patients were appropriately identified as having oligohydramnios. The test efficiency of AFI $\leq$ 5.0 cm to diagnose true oligohydramnios is 45% while the sensitivity, specificity, and positive and negative predicative values are 0%, 91%, 0%, and 48%, respectively. In comparison, the test efficiency of the AFI and the regres-

Table 1. Amniotic Fluid Volume (AFV) and Amniotic Fluid Index (AFI) Among the Groups Used to Derive the Mathematical Models (Group I) and to Validate Them (Group II)

	Group I (n = 42)	Group II (n = 22)
Mean AFV (ml)	935 ± 793	770 ± 1109
AFV < 500	15	11
AFV > 1500	7	1
Mean AFI (cm)	13.7 ± 6.9	13.2 ± 5.2
AFI ≤ 5.0	1	1
AFI > 18 cm	11	7

sion equation to detect oligohydramnios was 73% while the sensitivity, specificity, and positive and negative predictive values are 73%, 55%, 62%, and 67%, respectively.

To predict the actual AFV, the lowest mean percent error was with the second regression equation:

$$AFV = 533.54291 - 34.3682*AFI + 3.71631*AFI^2$$

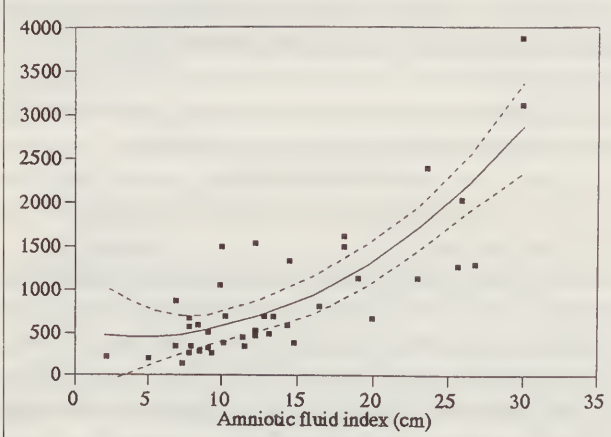


*Figure 1. Prediction of amniotic fluid volume (AFV) based on amniotic fluid index (AFI) and polynomial regression curve (AFV = 533.54291 - 34.3682*AFI + 3.7163*AFI²). Dotted line marks the 95th percentile.*

where AFV and AFI are amniotic fluid volume and amniotic fluid index, respectively (Fig. 1). The R^2 for this relationship is 67% with $p < 0.00001$. Among the 64 patients (group I plus II) the mean (± SD) percent error of predicting the actual volume with this equation was 23 ± 64%, while it was 147 ± 299% with the first equation we proposed to detect true oligohydramnios ($P < 0.001$; 95% CI 48 - 199).

DISCUSSION

Amniotic fluid index is a simple, reproducible and clinically useful method of sonographically assessing AFV.[3,4,10-13] The main disadvantage of this method of evaluating amniotic fluid is that it does not permit an accurate determination of true volume, as determined by dye-dilution technique. Magann et al[8] previously reported that among 40 patients, 15 had oligohydramnios (AFV < 500 mL) and the sensitivity of AFI in detecting this low amount of fluid was only 6.7%. Among the additional 24 patients, there were 11 who had oligohydramnios, and none of them had an AFI ≤ 5.0 cc. The inability of an AFI ≤ 5.0 cm to predict oligohydramnios prompted us to determine if with regression analysis, it is possible to correlate AFI and AFV as determined by dye-dilution technique.

Findings of this investigation reveal that with two separate regression equations one can maximize the detection of true oligohydramnios, and minimize the percent of error in predicting the actual AFV. For example, among the 64 patients there were 26 parturients with AFV < 500, but only one of them had an AFI ≤ 5.0 cm. Using the first equation, 22 of 26 patients were accurately identified as having oligohydramnios, while only 14 of 22 were appropriately identified as having amniotic fluid < 500 cm with the second equation ($P = 0.03$; odds ratio of 1.26 to 17.5). Both of the equations were significantly superior in predicting oligohydramnios than the AFI ≤ 5.0 cm (1 of 26; $P < 0.0001$).

A method to verify a mathematical model correlating AFI and AFV would be to see how accurately the equation will predict the actual amniotic volume throughout the gestation, as proposed by Brace and Wolf,[16] using Moore and Cayle's[14] data which describes the mean AFI through the gestational age. For example, Brace and Wolf[16] reported that between 22 and 39 weeks, the mean AFV averaged 777 ml. Using our second equation, and the mean AFI as established by Moore and Cayle,[14] we calculated that the mean AFV between 22 and 39 weeks should be 687 ml--a percent error of 11.5%.

In conclusion, AFI $\leq$ 5.0 cm is poor predictor of low AFV as determined by dye-dilution technique. With mathematical models, however, it is feasible to correlate AFI with AFV, and accurately predict which patient will low AFV.

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Addressing the Problem of Medical Malpractice

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Editors' Introduction

In the mid-1970s, physicians became concerned about the difficulty of obtaining medical malpractice liability insurance and, where coverage was available, the high premiums. The medical malpractice "crisis" of the 1970s led to legislative changes in many states and to reforms within the insurance industry. Although these reforms seemed to alleviate the situation for a time, it worsened again in the 1980s, raising concern about a new crisis. Although nobody was certain about the extent or the causes of the problem, various legislative and regulatory solutions involving tort reform were proposed.

At the time, few funders were supporting research and demonstrations on medical malpractice insurance. In 1985, The Robert Wood Johnson Foundation began its support of a range of initiatives on the topic. The Foundation's efforts represent a sustained attempt to understand the problems associated with malpractice and to help foster innovations in the way insurance issues are handled at the state level. Two national programs were supported: the first focused on research to document and explain the situation, and the second supported demonstrations and evaluations of actual reform efforts.

More than a hundred journal articles and reports have been written based on the research undertaken under the two national programs.

In many ways, the efforts of those involved in the various projects supported by the Foundation defined a field of research directed at addressing a long-standing problem. In Chapter Six, key people involved in the initiatives synthesize the findings and examine the implications of the Foundation's efforts.

The authors of this chapter were all involved in managing the Foundation's investments in this area. Joel C. Cantor was director of education research at the Foundation until January 1996 and is currently the director of the research division of the United Hospital Fund of New York. Robert A. Berenson, associate clinical professor of medicine at Georgetown University, directs the Foundation-supported Improving Malpractice Prevention and Compensation Systems (IMPACS) initiative. Julia S. Howard is the deputy director of the IMPACS project, and Walter Wadlington, the James Madison Professor of Law at the University of Virginia School of Law, directed the Foundation-supported Medical Malpractice Program.

Despite the press attention given to medical malpractice and the rising cost of malpractice insurance premiums, only recently have researchers focused on documenting the extent of the malpractice problem and finding solutions to it. In the face of firmly held conventional wisdom, many of the research findings are surprising. A Harvard University malpractice study, funded in part by The Robert Wood Johnson Foundation under the

Medical Malpractice Program, found that 1 percent of hospital stays in New York state involved medical negligence and that only one in eight of the patients affected by this negligence actually brought a malpractice lawsuit.

Moreover, the Harvard study found that the perceived risk of being sued in a given year was three times as great as the actual risk among physicians. Several other studies carried out under the program suggest that doctors' perceptions about their exposure to malpractice liability are simply inaccurate.

In 1985, after a decade of apprehension that harm to patients, and the system of compensation for such harm, could have a severe, adverse impact on physicians and health care institutions, The Robert Wood Johnson Foundation took steps to address these problems by initiating the *Medical Malpractice Program* (MMP). The program was designed to develop and analyze data on medical malpractice and its impact on health care delivery, and to develop strategies for reducing medical injury and adequately compensating medically injured persons. In 1994, the Foundation announced a second major program, *Improving Malpractice Prevention and Compensation Systems,* or IMPACS, which was intended to translate into action the lessons learned in the Malpractice Program by establishing models of malpractice prevention and compensation systems.

As the Foundation has done in many other areas, in medical malpractice it is attempting to effect a change in the system. Because of strong vested interests and systemic inertia, attempts to change a system carry a high risk of failure. If the Foundation's programs *can* bring about changes in social institutions, however, the potential payoff is enormous. The two malpractice programs were created to address the broad failures of current systems. In the view of those who framed the Foundation's malpractice work, the major problems were that:

•Malpractice lawsuits do not provide adequate incentives to correct the vast majority of medical injuries.

•The links between the institutions that address malpractice and the institutions intended to prevent injury and improve health care are weak at best.

•The system is inefficient; only about forty cents on the malpractice premium dollar compensates claimants; the rest goes for legal fees, court costs, and insurer costs.

•Periodically high cost and lack of availability of malpractice insurance have led to problems in access to care for vulnerable populations.[1]

THE MEDICAL MALPRACTICE PROGRAM

In 1987 and 1988, through the Medical Malpractice Program, the Foundation awarded nineteen grants totaling $4.5 million. (Table 6.1 on the next page lists these grants and three others that the Foundation awarded through its ad hoc grant-making process during the late 1980s and early 1990s.) At the time that this first program was developed, malpractice premiums had risen to the point of creating a crisis, as they had done in roughly ten-year cycles, but the Foundation staff and consultants could find little in the legal or policy literature to explain these cycles or offer options for addressing the resultant problems. These observations led to the Medical Malpractice Program, which focused on understanding problems and identifying potential solutions.

The Extent of Medical Error and Malpractice

In the 1970s and 1980s, many states passed malpractice legislation even though the legislators had little or no reliable data about the extent of malpractice or the effectiveness of the tort system as a way to compensate victims of medical injury. Two studies supported under the program shed considerable light on this area. The most widely cited of these is the Harvard Medical Practice Study,[2] which, we stated earlier, found that 1 percent of all hospital stays involved negligence and that only one in eight patients injured by negligence filed malpractice claims. This study, based on hospital records from New York state, also found that adverse events (whether or not they were caused by negligent conduct) occurred in 3.7 percent of hospital stays. These rates were similar to those recorded in a study of California hospitals ten years earlier, the basic methodology of which had been followed in the New York study.[3]

The findings of the Harvard study were reinforced by researchers at the University of Chicago, who measured the incidence of error in patient care in three surgical units.[4] Instead of focusing on medical records or insurance claims that had been closed, ethnographers observed hospital units and attended rounds and clinical meetings in which patient care was discussed. Although the purpose of the study was not simply to document the incidence of errors, one finding was that only a small percentage of the patients who were victims of medical error actually brought suit.

Physician and Hospital Practices

Clearly, the best way to prevent malpractice claims is to avoid or minimize the incidence of medical injury. If harm does occur, those responsible should try to mitigate it in a way that is acceptable to the patient. One goal of the Medical Malpractice Program, therefore, was to have the health care and legal communities develop workable responses to medical injury.

Table 6.1 Grants in the Field of Malpractice Made by the Foundation, 1987–1993.

MEDICAL MALPRACTICE PROGRAM ROUND 1

#	Grantee Institution	Principal Investigator	Amount Awarded	Purposes of the Grant
1	American Registry of Pathology	Maj. Frank T. Flannery, M.D., J.D.	$192,094	Prospective study of risk management and practice protocols in hospital emergency departments.
2	Amherst College	James W. Hughes, Ph.D.	95,579	Evaluation of the effect of malpractice reform laws of the 1970s on the number, size, and disposition of claims.
3	University of California, San Francisco	Harold S. Luft, Ph.D.	166,529	Study of the potential use of risk-adjusted liability insurance premiums for hospitals.
4	Harvard University, School of Public Health	Howard H. Hiatt, M.D.	275,937	Study of the incidence of iatrogenic injuries, economic losses, and relationship to malpractice litigation. (Principal funder was the State of New York.)
5	Indiana University Foundation	Eleanor D. Kenney, J.D., M.P.H.	260,094	Evaluation of Indiana's malpractice tort and insurance reforms of 1975.
6	Institute for Medical Risk Studies	Don Harper Mills, M.D., J.D.	231,060	Study of the feasibility and effectiveness of "early warning" systems for malpractice claims.
7	Johns Hopkins University, School of Hygiene and Public Health	Laura Morlock, Ph.D.	285,131	Evaluation of Maryland's 1986 law mandating reporting to a central database of physician disciplinary and tort actions.
8	Johns Hopkins University, School of Hygiene and Public Health	Stephen Teret, J.D.	207,702	Study of early risk factors for malpractice involvement of 1948–1964 medical graduates from Johns Hopkins Medical School.
9	University of Minnesota	Edward Ciriacy, M.D., and Doris Booker, M.D.	296,027	Study of high-risk pregnancies and development of medical-error risk-reduction education for physicians.
10	University of Pennsylvania	Patricia Danzon, Ph.D.	224,650	Study of the economic impact of potential changes in systems of malpractice compensation on physicians and consumers.
11	Private Adjudication Center of Duke University	Neil Vidmar, Ph.D., and Thomas Metzloff, J.D.	284,421	Develop pilot study of alternative dispute resolution (ADR) procedures in malpractice disputes.
12	Stanford University	John P. Bunker, M.D.	200,865	Study of the impact of anesthesiology practice standards on medical outcomes and malpractice claim risk.
13	University of Texas, Health Science Center	Laurence R. Tancredi, J.D., M.D.	300,000	Study of the feasibility of using a list of "accelerated compensable events" as part of a no-fault insurance approach.
14	Vanderbilt University, Institute for Public Policy Studies	Frank Sloan, Ph.D.	225,659	Study of the feasibility of using "damage scheduling" and experience-rated premiums in malpractice insurance.

Table 6.2 Grants Made Through Improving Malpractice Prevention and Compensation Systems, 1994 to Present.

#	Grantee Institution	Principal Investigator	Amount Awarded	Purposes of the Grant
1	Copic Medical Foundation (11/1/94 to 4/30/96)	K. Mason Howard, M.D.	$823,169	Feasibility study for and design of a non-fault-based malpractice compensation system in Colorado.
2	Utah Alliance for Health Care (11/1/94 to 10/31/96)	Elliot Williams, Esq.	729,520	Feasibility study for and design of an enterprise liability demonstration in Utah.
3	Center for Health Policy Research and Education, Duke University (6/1/95 to 5/31/97)	Frank A. Sloan, Ph.D.	526,013	Evaluation of Florida and Virginia no-fault compensation systems for birth-related injuries.
4	Wake Forest University School of Law (6/1/95 to 12/31/96)	Ralph A. Peeples, J.D. Thomas B. Metzloff, J.D.	98,446	Evaluation of court-ordered mediation of malpractice cases in North Carolina.
5	Children's Hospital of Vanderbilt University (1/1/96 to 12/31/96)	Gerald B. Hickson, M.D.	667,291	Demonstration and evaluation of a program of early identification of and response to malpractice risk.
6	Private Adjudication Center, Duke University (2/1/97 to 8/31/97)	Thomas B. Metzloff, J.D. Francis E. McGovern, J.D.	132,732	Planning for a randomized experiment to test mandatory arbitration for malpractice cases in the Philadelphia courts.
7	RAND Corporation (8/1/96 to 7/31/97)	Elizabeth Rolph, Ph.D. John E. Rolph, Ph.D.	177,225	Evaluation of contractual arrangements requiring alternative dispute resolution in managed care organizations.

Increasingly, health care professionals view the use of protocols, or practice guidelines as viable tools for improving medical and hospital procedures. Some also see protocols as means of clarifying the legal standard of care. One study examined the incidence of claims made by patients who went to an emergency room with chest pain or other symptoms but were not treated for myocardial infarction in a timely fashion. Protocols based on this information have been introduced in emergency rooms of military hospitals. Another team analyzed a ten-year database covering some five hundred California anesthesiologists insured by two physician-owned carriers and determined that insurer-introduced protocols had served to reduce claims and thus stabilize liability premiums.

Another study sought to understand whether certain practices or medical providers seemed to be prone to malpractice problems, so that strategies could be developed to reduce the number of events likely to lead to claims. Data on closed claims from a large New Jersey-based insurer were used to identify problem-prone clinical processes in four high-risk specialties: anesthesiology, general surgery, obstetrics and gynecology, and radiology. The investigators found that the claims histories of individual physicians were only modestly useful in predicting whether or not a claim might be filed and thus were of questionable help in targeting physicians for educational intervention or sanctions. On the other hand, the researchers concluded that for an entire system, malpractice data could be used to suggest interventions that might reduce negligence. They suggested that errors involving patients could be averted by such hospital practices as insuring the prompt delivery of test results to physicians.[5]

The majority of malpractice claims stem from harm that occurs to the patient in the hospital. Therefore, risk management programs that are based in hospitals hold potential for limiting substandard care and preventing and controlling claims. Three studies addressed aspects of risk management practices. One grantee explored whether there was a factual basis for concluding that hospital-based risk management programs actually affected the number of claims filed.[6] This study, of forty acute care general hospitals in Maryland during the early 1980s, provides the first large-scale evidence that risk management can help reduce malpractice claims.

Another grantee, in Chicago, addressed ways of developing systems that would bring problems of medical injury to the attention of risk managers as quickly as possible, so that relevant information could be gathered soon after any injury occurred. With this information, the

risk managers might be able to resolve a dispute to the satisfaction of the patient without expensive and time-consuming legal proceedings.[7] The project concluded that all hospital medical staff should be involved if reporting on incidence of medical injury is to be effective. This study also pointed to a need for a system that would function more effectively in passing along information about errors to risk managers, patient safety committees, or some part of the hospital administration.

Two other projects, in Oregon and Maryland, addressed the relationship between malpractice and medical credentialing, including state licensing procedures and the granting of hospital admitting privileges to physicians. The researchers in Oregon analyzed an eleven-year database from the state's Board of Medical Examiners to identify physician characteristics and practices that were associated with disciplinary actions and malpractice claims, and the team in Maryland developed guidelines to help hospitals use background information about physicians appropriately and avoid its misuse in the credentialing process. The guidelines were important because Maryland, unlike other states, required reporting of certain malpractice claims and disciplinary proceedings against physicians. Subsequent to this project, the National Practitioner Data Bank, which changed the way information about individual physicians is used in hospital credentialing procedures, was started.

Beyond credentialing or practice protocols, some people have suggested that the perceptions of doctors about legal risk can serve to deter substandard conduct, but others claim that such perceptions can also lead to defensive procedures - diagnostic or treatment measures designed to protect a physician or a hospital from liability rather than to promote patient health. Moreover, several studies under the Medical Malpractice Program suggested that physicians' perceptions about liability exposure are inaccurate. The perceived risk of being sued in a given year was three times the actual risk among physicians studied in the Harvard Medical Practice Study.[8] In a study in Florida, physicians' assumptions about likely malpractice claimants were shown to be unrealistic, and these assumptions varied according to the specialty involved.[9] Three studies supported under the program refute the common assertion that Medicaid patients make malpractice claims more often than others. Studies in the states of Maryland,[10] Washington,[11] and New York[12] revealed that the likelihood of claims from Medicaid patients was no greater than for non-Medicaid patients and in some instances was actually lower.

Whatever the basis for the fears of physicians, the potential result of those fears on doctor-patient relationships and on decisions that affect the cost of treatment or access to medical care can be considerable. The study in Washington state focused first on whether some physicians stop practicing because of a concern about malpractice claims. It found that the attrition rate was small but, because of an already existing shortage of physicians, significant in impact.[13] A further study adding Alaska, Montana, and Idaho found that despite tort reforms, the cost of liability insurance and a concern about the likelihood of being sued continued to limit the number of physicians engaging in obstetrical care.[14]

Understanding and Refining the Legal System

Seven of the projects in the Medical Malpractice Program added significantly to understanding of the effects of conventional tort reforms since the late 1970s and of the functioning of malpractice dispute resolution in general. These projects include studies of the effectiveness of the existing tort system as well as evaluations of tort reforms.

Along with contingency fees and damages for pain and suffering, the civil jury system is among the components of the present compensation system criticized most widely by members of the health care establishment. But one program study found no support for assertions that juries are consistently pro-plaintiff, incompetent, or unjustifiably generous in their awards. The study did find, however, that jurors would like to have greater guidance from judges, particularly with regard to damages.[15]

Fixing the amount of money to be awarded in a malpractice case can be especially controversial. Some critics point to the seeming inconsistency in damage awards, while other critics contend that awards are frequently too high. The distinction between economic and noneconomic loss is of particular importance. These issues were the subject of an extensive Florida study of closed claims for severe birth-related injuries to children and emergency room injuries to adults. In this study, claimants who actually recovered monetary damages received only about 80 percent of the costs that resulted from their medical injuries.[16] The investigators also found that less seriously injured persons received proportionately greater compensation than severely injured persons. They sounded a cautionary note to the effect that the perception that the tort system works poorly may be unduly shaped by publicity about the relatively small number of claims that result in high damage awards.

Indiana was in the forefront of states that enacted broad tort reforms for medical malpractice. Changes included a cap on damages and led to the creation of a patient compensation fund to pay all awards in excess of

$100,000, financed by a surcharge on the medical providers' basic liability premiums. Under this system, insurers accepting the first $100,000 of liability in a given case refer the rest of the claim to the compensation fund for settlement. Medical review panels were then created to determine the extent of payment that would be made available under the fund. In an evaluation of the severe-claims experience under the Indiana system compared with that of neighboring states without damage caps, investigators found-to the surprise of some observers-that under the Indiana reforms only a small fraction of claims went before the medical review panels for their determination of liability and that large claims resulted in comparatively generous compensation.[17] The investigators suggest that the Indiana cap may have inadvertently established what amounted to a no-fault system for large claims.

Some reformers have proposed that medically injured persons must submit their claims to an alternative dispute resolution process, at least initially, as one way to overcome common complaints about the trial system. There are many possible ways to resolve disputes, including arbitration and mediation. The suitability of various procedures in resolving malpractice disputes was examined in one study funded under the program. After analyzing procedural steps taken in malpractice cases that had been litigated in North Carolina, the investigators conducted demonstrations of several approaches, including mediation and arbitration of actual cases that were referred to them through the court system with the agreement of the parties.

One innovative alternative was the use of a summary jury trial in specific cases in which the parties agreed to limit the number of factual issues in dispute, the number of expert witnesses, and the over all length of the trial.[18] The parties also agreed to the imposition of a floor and a ceiling on damages. The investigators concluded that the cases most appropriate for summary trials were those in which liability was unclear but potential damages would be great if the recovery was granted.

Researchers in other projects developed or evaluated approaches that would award damages more fairly than the current system and better tailor damages to the needs of medically injured persons. These include development of a plan that would give damage awards precedence in future cases,[19] payment for the future medical services an injured party needs through an insurance contract tailored to specific cases rather than as lump-sum payments,[20] and the introduction of "scheduled" damages-specified compensation for specific injuries-for pain and suffering in medical malpractice awards.[21]

Evolutionary and New Compensation Approaches

In addition to identifying problems that are posed by the way medical malpractice is handled in medical and legal systems and evaluating the major reforms of the 1970s, the program supported work intended to lead to alternatives to the existing systems. Three types of reforms were studied by Foundation grantees.

The idea of a liability system for medical injuries that would rapidly provide fair compensation for certain injuries without need to prove negligence is by no means new. However, past attempts to develop a workable system on such a basis have encountered difficulty in defining what constitutes an appropriate "compensable event." One such approach was developed using a large database of obstetrical injuries on which successful liability claims were founded.[22] The investigators selected the new term *ACE (for accelerated compensable event)* to describe the triggering basis for recovery. Although compensation for an ACE would be awarded without proof that it was caused by negligent conduct, experts would generally agree that ACEs should seldom occur in standard medical practice.

ACEs are classes of medical injuries that are readily identifiable and relatively avoidable-in this study, preventable in at least 70 percent of those cases that receive good care. An accelerated compensable event system would not replace the tort system completely, because not all medical injuries would be covered under ACES. However, the developers of the system estimate on the basis of past claims that between one-half and three-quarters of obstetrical claims would be covered. In concept, ACEs could be extended to much broader classes of medical injuries.

Another project supported by the Foundation examined an even broader reform proposal. The medical malpractice portion of the *Reporters' Study on Enterprise Liability and Personal Injury* for the American Law Institute included a proposal for shifting liability from individual physicians to hospitals or other health care institutions connected with incidents giving rise to claims, except in intentional torts.[23] This approach, called "enterprise liability," would have much greater administrative efficiency than the current system in cases involving multiple defendants and would provide for more-even distribution of malpractice insurance costs that now vary greatly by specialty. Proponents also assert that enterprise liability appropriately reflects changes in the structure of medical practice today, and that it would shift legal responsibility for preventing injuries and improving quality to the institutions that are in the best position to do those things. Such incentives are appealing in light of the

findings that the best prospect for reducing injuries is from changes in the system rather than from targeting individual physicians who are at high risk for committing errors.[24] Some who are skeptical about or opposed to such an approach worry that it lessens the deterrent effect of the current tort system, or leads to limitations on physician autonomy.

Finally, no-fault- compensation would eliminate one of the most difficult and troubling steps in the present tort system, the finding of fault. Under a no-fault scheme, medically induced injuries are compensable regardless of a finding of negligence. Proponents of a no-fault approach contend that a properly structured plan can provide fair compensation for a greater number of injured parties because of substantial reductions in administrative and other costs. Expenses might be lowered if damages for some types of noneconomic loss were reduced or eliminated. Some suggest that the deterrent effect of the current tort system on substandard care can be (and perhaps has been) substantially replaced by other controls, and that a no-fault system could provide the incentive to reduce all medical injuries. The Harvard Medical Practice Study[25] estimated that a comprehensive no-fault approach would cost no more than the current system but would distribute compensation more broadly and equitably.

Accomplishments and Unmet Aspirations

The most tangible result of the program was a body of research findings: a collection of more than one hundred articles, working papers, books, and reports from the legal, medical, economics, and health policy fields. The success of a program should not be gauged simply by a count of publications, however, but rather by the value and impact of the research reflected in them. In this regard, it is significant that many of the studies provided cornerstones for the current debate among policy makers;[26] others are helping shape new approaches in areas such as risk management and compensation for medical injury (including some with the support of the Foundation-funded IMPACS initiative). Another important accomplishment, although it is a difficult one to quantify, was that the program came to serve as a liaison among researchers from different disciplines-people who had little or no prior contact. In many cases, productive collaboration among program participants continues today.

The program contributed significantly to what is known about the dimensions of medical error, how medical providers view and respond to the current malpractice system, and how the problems of the current system may be overcome. But even the substantial body of research amassed does not address all the important questions raised by policy makers, health care managers, and medical practitioners. Nevertheless, several generalizations can be made from the studies supported under the program:

- Provisions in the health care and legal systems to identify, prevent, and compensate medical injuries are seriously flawed; indeed, the great majority of injuries go unidentified by those suffering them.
- Various stakeholders may view malpractice-related problems differently. Medical providers see the system as arbitrary, for example, while policy analysts emphasize lost opportunities for stronger incentives to prevent injuries and to compensate injured parties fairly.
- Risk management and related mechanisms can be effective, but they are not now sufficiently broad-based and active enough to make a significant contribution to reducing the problem of medical malpractice.
- The best opportunities to prevent medical injuries are in changes to the organization of care rather than in targeting "bad apple" providers.
- Current methods of claims adjudication operate more fairly than many have suggested, but they are slow, expensive, and adversarial and thus compound dissatisfaction in the malpractice arena. Alternative dispute resolution techniques have not been widely adopted.
- There exist promising new approaches to malpractice problems that are ready to be adopted, at least on a demonstration basis.

The most significant obstacle that surfaced early in the Medical Malpractice Program was that many researchers found themselves confronted with unanticipated and often unexplained barriers to data sources, even though the owners of the data had assured them access. In the malpractice arena, more than in other areas of health services, assertions by data providers about confidentiality and potential liability are barriers to research. Generally, claims-related research is limited to closed cases; even so, some malpractice insurers and health care organizations are reluctant to share information. Further research on malpractice requires that keepers of data be willing to open their books.

One area still in need of substantial research is the phenomenon of "claiming behavior"-a special concern, given our knowledge about the relatively small percentage of negligently injured persons who file claims or instigate lawsuits. Also in need of detailed focus is defensive medicine, thus far discussed largely in broad-brush generalizations and a few careful but narrow

studies.[27] Other research topics include problems associated with increasing ambulatory care and expanded autonomy of allied health care professionals, the effects of changing practice structures and managed care on fixing liability, special issues of rural practice, the potential impact of outcomes research, and the effects of introducing or withholding new technology or complex procedures on standards for determining liability.

IMPROVING MALPRACTICE PREVENTION AND COMPENSATION SYSTEMS (IMPACS)

As the findings of the research supported under the Medical Malpractice Program came to light, the Foundation shifted its emphasis to applying possible solutions to the problems of malpractice-related systems. In July 1994, the Foundation launched IMPACS, a program that made as much as $6 million available for recipients to prepare, implement, and evaluate demonstration projects. Resources could also be used to evaluate policy changes and demonstration projects that are not funded by The Robert Wood Johnson Foundation. The Foundation, through an external program office and advisory committee, used a combination of two rounds of competitive applications and solicited projects on specific topics that were supported under IMPACS.

As a result of the knowledge gained in the Medical Malpractice Program, the Foundation and its advisers felt that the timing was right for a demonstration initiative such as IMPACS. The history of ten-year cycles in malpractice claims suggested than another crisis period could be expected to begin in the mid-1990s. As in the past, an upsurge in malpractice claims and insurance premiums could be expected to generate considerable interest and political will for reform. It was believed that an interest in reform would spur support for broad demonstration projects.

The Foundation was looking for projects in four broad areas:

1. Providing more appropriate incentives for preventing medical injuries, without giving rise to costly defensive medicine or adversarial provider-patient relationships

2. Incorporating malpractice risk management into quality improvement initiatives of health care organizations

3. Achieving greater efficiency or lower overall cost in processing medical injury claims or compensating injured patients by nonadversarial systems

4. Providing benefits that are more consistent with actual damages for a significantly greater proportion of injured patients

Through the mid-1990s, no new upsurge in malpractice claims or premiums has occurred, and consequently no groundswell of interest in reform projects has emerged. Nevertheless, serious interest does exist, and IMPACS has attracted and is funding a wide range of significant projects.

IMPACS Projects Supported So Far

Table 6.2 (next page) lists the projects supported through IMPACS to date. The first two involve planning and feasibility analysis for comprehensive reforms in how malpractice claims are handled in Colorado and Utah.

In both projects, members of the Harvard Medical Practice Study team are conducting local versions of the New York study. In both cases, estimates of the incidence of adverse events and malpractice claims are to be made and the costs of the alternative compensation system are to be compared with those of the existing tort system. The design and implementation plans for these two demonstrations also differ in important ways.

In Colorado, staff at the Copic Medical Foundation, the not-for- profit arm of the major doctor-owned medical malpractice insurer in the state, are working to develop an alternative to the tort system. The alternative channels all known cases of medical injury into an administrative system that determines whether a medically related injury took place, and what level of compensation should be granted to injured parties. The system would not require proof of fault before compensation was awarded. The Copic reform model has several advantages over the current fault-based system, at least in theory. First, it provides compensation to a broader range of injured patients and families, and more quickly than the existing tort system does. Second, it is linked to systems of quality improvement and medical discipline, thereby giving clearer and stronger signals for the prevention of future medical injuries. Moreover, such signals reflect medical injuries of all kinds, not just those that result from negligence. Finally, the system is designed to cost no more than the existing tort system, but significant administration and adjudication costs are redirected into patient compensation.

Copic is creating a detailed design for a model administrative/no-fault system, studying the cost of the reform model, and working with interested parties to refine the model. A number of difficult issues must be resolved as part of the planning process. For instance, how would levels of compensation be determined for specific injuries? What appeals processes would be allowed? And how would the compensation system be

Table 6.1, continued

MEDICAL MALPRACTICE PROGRAM ROUND 2

#	Grantee Institution	Principal Investigator	Amount Awarded	Purposes of the Grant
15	University of Chicago, Department of Surgery	Thomas Joseph Krizek, M.D.	$290,470	Study of factors that influence patient malpractice-claiming behavior.
16	Maryland Department of Health and Mental Hygiene	Mary G. Mussman, M.D., M.P.H.	87,498	Study of the relative risk of malpractice claims in low-income versus other populations.
17	Oregon Foundation for Medical Excellence	Dennis J. Mazur, M.D.	293,072	Development of a predictive tool to help identify physicians at high risk of malpractice claims or disciplinary actions.
18	Vanderbilt University, Institute for Public Policy Studies	Frank A. Sloan, Ph.D.	299,393	Study of malpractice-claiming behavior and economic outcomes of claims.
19	University of Washington, Department of Family Medicine	Roger A. Rosenblatt, M.D., M.P.H.	295,093	Study of the impact of malpractice systems on access to obstetrical care for poor and rural mothers.

AD HOC GRANTS ON MEDICAL MALPRACTICE

#	Grantee Institution	Principal Investigator	Amount Awarded	Purposes of the Grant
20	RAND	John E. Rolph, Ph.D.	$199,997	Study of using malpractice claims data as a medical care quality-improvement tool.
21	American Law Institute	Paul C. Weiler, J.D.	367,172	Feasibility study of enterprise responsibility for medical injuries, size and disposition of claims.
22	University of Pennsylvania	Patricia Danzon, Ph.D.	49,993	Study of the Swedish system of no-fault medical error compensation.

coordinated with other sources of funding for medical care and disability, including Medicaid, Medicare, the workers compensation system, and employer-based health insurance? After the model is completed, the proposed reform will probably require state legislation before it can be put into place.

The Utah project is designing a broad-based reform by studying the incidence of medical injury and claims and comparing the costs of a new system with those of the status quo. The model of reform in Utah is different from the Colorado project in several important ways. The former is building on work done under the Medical Malpractice Program, which developed the concept of enterprise liability or responsibility in medical malpractice. In this model, individual doctors are relieved of legal responsibility for medical error, and institutions-most likely hospitals-take on full responsibility. One important advantage of this proposal is that responsibility for preventing medical errors is at a level where systemic interventions can be used. Also in the Utah project, systems for identification of and compensation for medical injury are aligned with quality improvement programs at hospitals. Unlike the Colorado project, the Utah Alliance for Health Care plans to conduct a demonstration of its concept in certain Utah hospitals. As in Colorado, a number of important issues have to be resolved before the demonstration can go forward, such as how to obtain informed consent for patients in demonstration hospitals.

Three other IMPACS projects are evaluations of policies already in place at the state level, and a fourth involves a rigorous study of a new intervention in the Philadelphia area. Frank Sloan and his colleagues at Duke University are evaluating no-fault compensation systems for birth-related neurological injuries in Florida and Virginia. Birth-related injuries are relatively infrequent, but when they do occur they are expensive, and they have been at the center of malpractice concerns in obstetrics nationwide. Florida and Virginia have established funds to compensate families of injured infants without resorting to the tort system. These are currently the only no-fault systems operating in the malpractice arena in the United States, and the evaluators will learn lessons for the broader application of this concept.

A second evaluation project, being conducted at the Wake Forest School of Law, is studying North Carolina's program for court-ordered mediation of malpractice cases. This evaluation compares the program's performance with respect to settlement rates, disposition time, and cost with the performance of the traditional court system.

A third evaluation project, to be run by RAND, is

a descriptive case study of the use of alternative dispute resolution, or ADR, for malpractice and coverage disputes in managed care organizations; it is to develop measures of the cost-effectiveness of these programs. The investigators are designing and testing a way to gauge provider attitudes about ADR. The use of ADR in managed care coverage disputes and malpractice allegations may be a way to avoid costly and lengthy lawsuits while still allowing for the fair resolution of claims.

Another ADR effort, to be carried out by the Private Adjudication Center of Duke University Law School, is developing, implementing, and evaluating a court-ordered arbitration model for use in medical malpractice cases. In concert with the state court system of Pennsylvania, the investigators will develop a rigorous examination of the costs and benefits of this type of ADR.

One other project now supported by IMPACS combines demonstration and evaluation. In this project, investigators at Vanderbilt University Children's Hospital are collecting data from multiple sources to identify physicians and clinical situations that receive a high volume of complaints. Prior research by these investigators demonstrated that the volume of general complaints about a physician is associated with an elevated risk of malpractice claims. The information is to be used to develop methods of correcting poor practices. The evaluation will then determine if the program leads to a reduced incidence of malpractice and related claims.

The Future of IMPACS

None of the projects supported to date under IMPACS is far enough along to declare success, or even to generate significant lessons. The researchers are expected to complete their findings in 1997 and 1998. Some of the projects may receive renewal grants for follow-up activities or broadening their work, and there are still several proposals being reviewed that could lead to new IMPACS grants.

CONCLUSION

Within the American health care system, the problem of medical malpractice is not high on the agenda of policy makers; nor is it high among the priorities of those who manage private health care organizations, except for those who must deal with the problem directly. It is natural to ask, then, whether the relatively modest efforts of a private foundation can make a significant difference in this area. Part of the answer is coming as the IMPACS projects play out. Ultimately, though, an answer may not come until a widely perceived malpractice crisis creates the demand for reform. At the very least, much more is known today about the causes and the consequences of malpractice and the functioning of systems for identifying, compensating, and preventing medical injury than was known before The Robert Wood Johnson Foundation launched its initiatives.

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Since 1972, The Robert Wood Johnson Foundation has been the nation's largest philanthropy devoted exclusively to health. To further its mission of improving the health and health care of all Americans, it provides funds for demonstration projects, educational activities, and research. The Foundation is dedicated to educating the public about health care innovation through findings from the projects it supports. In ***To Improve Health and Health Care 1997- The Robert Wood Johnson Foundation Anthology,*** the editors look into the most current investigative efforts funded by the Foundation.

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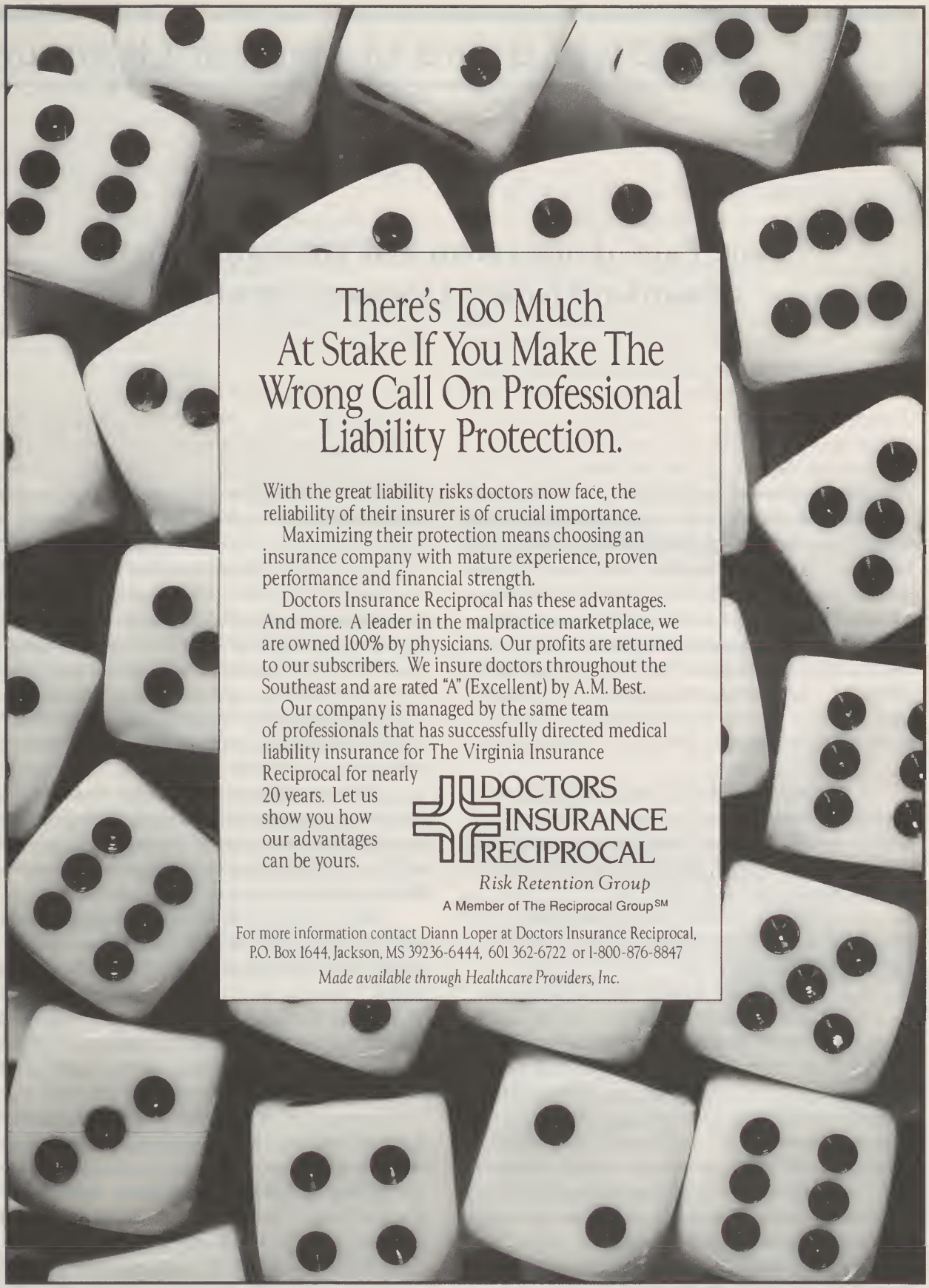
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Pain, Pain Management and Mississippi State Board of Medical Licensure Scrutiny

The skillful management of pain is one of the most valuable services a physician can provide. This service calls into play many components of the art and science of medicine and the technological skills that physicians possess. The result of pain management, skillfully done, is most rewarding to the patient and physician alike.

In many respects, the mechanism of pain is a mystery, but it is a mystery that is being progressively untangled. There have been many advances in our knowledge, allowing a better understanding of pain mechanisms and the therapeutic approaches to pain:

We now know that:

1. Pain may be perceived peripherally, at several levels in the spinal cord and mid brain, and in the central nervous system. This knowledge allows pain to be classified and to be treated in different ways, depending on the level where it is perceived.

2. There are natural-endogenous agonist and antagonist influences and some knowledge of how these can be brought into play.

3. There are many factors which influence pain, i.e.: a.) The patient's general situation with his family, employment, finances, spirituality, marital status, et al.; b.) The patient's previous responses to pain and to pain medications; c.) The patient's disease, whether it is due to an acute problem where healing and return to normal is expected, a terminal problem where progression of the disease to death within an estimated six (6) months or less, or a chronic non-terminal source of the pain where neither of the outcomes stated above is expected; and d.) The patient's attitude toward the pain.

4. Pain therapy is multimodal and with the above knowledge, a plan of therapy can be selectively evolved that is effective in most cases. A general recitation of these modes is as follows: a.) Behavior modification-psychological evaluation and intervention; b.) Physical therapy ranging from therapeutic exercises and joint manipulation to a variety of modalities including hydrotherapy, thermotherapy, manipulation to change threshold of sensory nerve ends (TENS), and others; c.) Analgesics to include NSAIDS, antidepressants and anticonvulsants; d.) Where indicated, a variety of maneuvers ranging from nerve blocks to ablative surgery; and e.) Controlled substances, including drugs for anxiety and depression, as well as opioids of appropriate strength.

With a working knowledge of all these things, the physician, using good clinical judgement, can create and carry out a plan that will satisfactorily resolve most pain problems and minimize the side effects and potential side effects of all these modes of therapy.

Many physicians are astute in the management of acute pain associated with surgery, trauma, and procedures. A growing number of physicians are becoming adept in the management of the pain of terminal disease. These terminal diseases include a number of cancers, AIDS, a number of progressive neurological diseases, end-stage heart and lung disease, and a variety of other disorders.

Adequate relief of acute pain requires regular doses of an ample amount of medication, as well as supportive measures with physical therapy therapeutic exercises, i.e., walking and breathing exercises, et al. Here the physiologic injury is soon repaired, and the patient returns to normal.

Palliative terminal care requires much supportive treatment involving psychosocial, pastoral care, physical

therapy, family therapy, and a degree of occupational therapy. Compassionate care on the part of all care givers to the patients and their families is a must. Medication must be managed skillfully to assure that increasing amounts are appropriate. Therapy and medication are required for the wide variety of problems that inevitably arise with these situations.

The ability to help patients to die graciously and in comfort has traditionally been an outstanding asset of physicians who care for these patients.

The Mississippi State Board of Medical Licensure supports the adequate treatment of all pain. In the acute and terminal categories of pain, the Board's concern is that they not be under treated.

Chronic pain of the non-terminal disorders is where problems arise. It is here that skills in pain management are stretched to the limit. All of the skills embodied in the art and science of medicine and the technologies involved in pain management are called into play.

Successful management in the case of chronic non-terminal pain requires:

1. Patient evaluation skills to provide a diagnosis and mechanism for the pain.

2. Management skills in evolving a plan of therapy that brings all the multimodal elements of the therapeutic armamentarium under consideration and selects out those that are most appropriate in each particular case.

3. Self-evaluation skills to know what you know, and to know what you do not know, and to know when consultation may be sought with pain specialists, addictionologists, orthopaedic surgeons, neurologists, neurosurgeons and others who can provide help in establishing a diagnosis and a mechanism for the pain, and can help evolve an appropriate plan of therapy.

4. Appropriate and timely monitoring of all modes of therapy including medications.

5. Awareness of and a watchful eye for the possibility of drug dependency and/or addiction where controlled substances are used.

6. Documentation of all evaluations, the plan of therapy, observations made on follow-up visits (especially the response to therapy and the continuing need for therapy, including everything but especially with regard to controlled drug use). Remember, if it is not documented, who is to say that it happened.

WHAT DOES THE LICENSURE BOARD REQUIRE OF YOU?

I. The Mississippi State Board of Medical Licensure publishes a book entitled ***LAWS, RULES AND REGULATIONS GOVERNING THE PRACTICE OF PHYSICIANS M.D./D.O.) AND PODIATRIST (D.P.M.).*** Section 2 of this publication is entitled *"Rules Pertaining to Prescribing, Administration and Dispensing of Medication."* We strongly suggest you familiarize yourself with these rules and regulations based on the law.

II. Follow all of the steps described in the section on the successful management of non-terminal chronic pain.

III. Know that a medical record documenting all things is not only part of good patient management but allows any outside agency (such as the Mississippi State Board of Medical Licensure) that may examine these records to have good insight into what was done, medications prescribed, dosage of medications, how often medication is given, and time period medication is prescribed.

IV. Know that the Board will have no quarrel with you if: (a) an appropriate good faith history and physical, along with other appropriate studies to make a diagnosis and to understand so far as is possible the mechanism of the pain; (b) a plan of therapy is evolved and utilized using all the available modes of therapy available and appropriate for each particular patient; (c) appropriate consultation is obtained; (d) controlled substances are used only after all other measures and non-controlled analgesics are found to be ineffective; and (e) all of this is timely and appropriately documented.

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Note: This broad overview is intended as a beginning effort to deal with a complicated subject. Response from anyone who would like to comment is welcome. The Board will ask for formal response from Pain Specialists and Addictionologists which will also appear in a future issue of the JOURNAL MSMA.

Nomination
1998 Community Service Award

The **Annual Physician Award for Community Service,** sponsored by Mississippi State Medical Association is designed to provide recognition to members of the association who are actively engaged in the practice of medicine, for the many and varied services above and beyond the call of duty which they render to their respective communities.

Each recipient of the award is nominated by his or her component society and selection is made by the members of the Council on Public Information. The intent of the program is to honor only living persons, and to honor no person more than once. Presentation is made at the annual meeting of the association's House of Delegates. Every society has many members worthy of this distinguished award. It is your society's responsibility to see that they are nominated. **All nominations should be submitted to the Mississippi State Medical Association by February 26, 1998.**

The award is a handsome plaque which features a cast bronze medallion. The medallion's design symbolizes the close relationship between medicine and the community. **A $500 contribution** is also made by the association to a civic organization designated by the award recipient.

Nominations should be submitted in writing. There is no particular form required in this regard; however, since the award is for outstanding community service it is important that all accomplishments of the nominee in this regard be presented in detail. The Council on Public Information encourages you to seek the assistance of the your local MSMA Alliance in preparing the written nomination and supporting materials.

Nomination supporting documents may include all or some of the following: a narrative about the person and his community involvement, newspaper clippings, letters of support from community leaders, newspaper or magazine articles written about the person, photographs and other materials that show the persons community involvement.

Nominations should be sent to MSMA, P.O. Box 5229, Jackson, MS 39296-5229, as soon as possible but no later than February 26, 1998. For further information please contact: Karen Evers, Director of Communications, (601) 354-5433 or 1-800-898-0251.



H. Vann Craig, M.D.

The President's Page

New Year's Resolutions

This year I'll...

1. Take off a day from the office to attend the Health Issues Seminar / Legislative Reception on Tuesday, January 13th at the Crowne Plaza Hotel in downtown Jackson.

2. Call my Senator or Representative every time I get an ALERT in the MSMA Blue Sheet.

3. Periodically contact my two Senators and my Representative in Congress to let them know my concerns on the Health Legislation that they are considering.

4. Mark my calendar to attend the MSMA Annual Session in Biloxi, May 13 - 17th.

5. Remember that the AMA represents ALL physicians to the best of its ability but, is a democratic process run by US - the physicians of the United States.

6. Spend more time with my patients to show them I care about them, as well as care for them, and that Managed Care is a secondary consideration in our relationship.

7. Lose weight, get in shape, and spend more quality time with my family.

Happy New Year!

Vann

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Editorial

JOURNAL OF THE
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Resolutions: In One Year and Out the Other

"When as a child, I laughed and wept....Time crept.
When as a youth, I dreamed and talked....Time walked.
When I became a full grown man ....Time ran.
When older still I daily grew....Time flew.
And soon I will be passing on....Time gone."
-Unknown.

The expiration of yet another calendar year causes us to again reflect on the precious and irretrievable nature of time. This introspection continues to provoke some folks to actually go to the trouble of making New Year's Resolutions. The only one I ever made that I kept was a few years back when I resolved quite simply to stop making New Year's Resolutions. Not only are they a waste of time, but generally prove to be a great source of guilt later on when you invariably break them. I prefer instead to have a "Mission Statement" for the upcoming year. For 1998, my mission is to become a better steward of my time.

Now, some of you have more money than others. Some of you are better looking than others. Some of you have more strength than the rest. But, one thing's for sure, you all have the same 24 hours in your day as everyone else. We all have 1,440 minutes that God gave us. Just think .... 86,000 seconds. And you hear people saying the excuse that never ceases to irritate... "Get somebody else to do that, they have more time than I do." Or, "I'm too busy, I don't have any extra time to do that."

There is enough time in each day to do gracefully all the things we need to do. It is a matter of prioritizing and largely, I have found, identifying and eliminating activities that squander time. For physicians, the identification of time wasters is easy, their elimination is quite another story.

If you think hard about it just for a moment you will realize that in the medical profession your acquired knowledge coupled with blocks of your time are the only wares you have to sell. We don't hawk a product. We don't manufacture anything. And when something or someone wastes our time, they are wasting a portion of our very lives!

Let me tell you about a few things I've discovered to be wasters of time for me.

I admit it. I have "magazinitis." I am powerless to the lure of those glossy periodicals that beckon me like Ahab on Moby Dick at each checkout counter. Titillating titles like "How to Make Love 20 Times A Night, 365 Days A Year," or "Lose 50 Pounds Of Ugly Fat Painlessly In 14 Days!"

What's worse is those bargain rate professional subscriptions for my waiting room. We subscribe to several (ahem... .of course they are for the patients) and certainly I have to approve them first before they fall into unsuspecting patients' hands. I cull out the magazines with feature articles like "Is Your Doctor Trying to Kill You?"

The problem isn't just lay magazines, there are dozens of medical journals, pseudo-medical journals and mail-order catalogues which bombard me daily. Around the holidays especially those catalogues seem to come in droves... sometimes three or four of the same in one day! I wouldn't mind them quite so much if they just made good kindling for the fireplace. A few of them are a welcome source of finding "that special gift for the hard-to-buy-for person on

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

your list." I have found that "hard-to-buy-for people" generally fit into that category because they already have too much of everything, so buying for them is a big waste of time and money anyway. Mostly these mail-order wish books just make me want gizmos and clothes that I really don't need. So to ameliorate my problem of being overwhelmed by reading material, I have learned to speed-read more effectively, not more efficiently. Efficient speed reading means voraciously scanning hundreds of words at lightening speed. Effective speed-reading is picking out a 50,000 word volume or treatise that I really don't need to read, then I don't read it. Look how much time I've saved!

Television can also siphon off some valuable hours. I used to watch the nightly news religiously. Then I decided that I really didn't need to know what the Memphis City Council voted on today, or to learn how many people were inconveniently blown away in convenience store robberies in downtown River City. I hear more tales of woe in a day's time than I care to already.

Watching ball-games on T.V. is a heinous time-eater as well. In tomorrow morning's paper you'll learn who won or lost, what the score was, and find out which players really shined. That is if you're interested. If you are not, then speed-read right past it to the comics page .... which by the way is not a waste of time. Anything that makes you laugh does not qualify as a waste of time.

You can speed-read books or throw them in the trash easily enough. You can flip off the television quite readily. But, what about the people who expertly consume your time at work each day? They can't be dispensed with so handily.

An example in the office would be home health agencies. They provide a wonderful service to many homebound patients. Their nurses are among the best and the patients adore them. They love them too much in fact. If you ever put someone on home health, the patient and their family quickly become addicted. Like anything addictive, there exists a great potential for abuse. And you can almost never discharge a patient without looking like a heel.

Families love the convenience ... patients love the constant attention...and they all especially like the price! In fact, you may actually not ever lay eyes on your patient in your office again.

If the patient gets a lot better they get dismissed from home health. Invariably a family member will come to you tearfully asking you to "do something, think of some way to keep Mama on home health." After all, they say, "Who is going to bathe her if she gets cut off?" I'm always tempted to retort, "Well, heck, who has been washing her rear-end for the past 85 years? If she can't, well maybe then it's your job, sister. After all, she washed yours for quite a while." I wish I was meaner and I would say things like that. I could save myself a lot of time if I was meaner.

A busy practice might have a dozen or so patients actively receiving home health. Almost inevitably everyday each one of them must have his chart pulled to deal with some problem or question about his condition, to handle lab specimens, to have a medicine called-in, to fill-out or sign yet another form, or to file the copious paperwork that has been generated to justify it all. Every single employee has to spend great chunks of time each day dealing with the "Home Health Machine," and the buck stops with me. The physician, then, is at the end of the Home Health Chain, being interrupted from concentrating on patients physically in the office, listening to the problem, making cognitive treatment decisions and ultimately assuming responsibility for the care.

And Medicare pays the physician's office literally nothing for our end of the service. It is just too hard to pin down, too hard to prove that we actually "did" anything.

Enough time spent on that soap box. Sales people can really get my goat, too. I'm not just talking about pharmaceutical representatives. A great many of these folks have been dear friends over the years and I'm always glad to see them. Learn something from them. Have never had to buy pens or "sticky-notes" because of them.

A few of them, however, seem to represent science's first efforts at human cloning. Identify them and don't let them in your office. And especially don't waste time with a district manager. Refuse to see them with your pharmaceutical representatives. That is unless you are feeling particularly masochistic and would rather spend thirty minutes listening to a canned sales "performance" while you could be out having lunch.

But, people will consume your time when you go out of the office as well. You might even begin to think you're a super star. Everybody knows your name. Everybody stops you to talk. You can't eat a meal in a local restaurant in peace without being consulted for medical advice by waitresses and customers. I stopped eating at one place because I grew tired of a particular waitress' penchant for discussing her chronic vaginitis over my soup and salad.

Did you ever really ponder from whence your immense popularity springs? With rare exception everyone who seeks out a physician's time either wants something, needs something or has something to sell you. Sometimes it is all three rolled into one.

If you are ever to be happy as a physician you will have to accept this as a fact of life.

It's funny if you think about it. We spend, say ... twenty years, our entire young lives looking forward to and working toward becoming a physician. And, if we're real lucky, twenty years or so after retirement age looking back and relishing those beautiful memories of having been a physician. And we spend the thirty or forty years in between complaining about how miserable we are being physicians.

What's wrong with this picture? Why are we constantly either hoping for the future, either regretting or idealizing the past, while we simply endure today? Why don't we just enjoy being a physician in the here and the now?

Some sage person once said, "Yesterday is a cancelled check. Tomorrow is but a promissory note. Today is the only cash in hand we have. Spend it wisely."

Fellow physicians, squeeze every drop of juice you can out of today. And remember that there are two groups of people that are never a waste of your time - your patients ... they are your livelihood, and your family ... they are your life.

TEMPUS FUGIT!

Dwalia South, M.D.
Associate Editor

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Mrs. James Grant Thompson Dies

Mrs. James G. (Elizabeth) Thompson, a past president of the MSMA Auxiliary (Alliance), died on November 22, 1997 of heart failure at Ocean Springs Hospital. Both she and her late husband were active in medical organization activities. He served as "Historian" for the Second Edition of the *MSMA History* published in 1949. Mrs. Thompson established the Thompson Memorial MSMA Past President's Pin and Thompson-MSMA Memorial Lecture on behalf of Dr. Thompson.

Awards In Medical Malpractice Court Cases Double Between 1985-1995

The average payment to injured patients in medical malpractice court cases has almost doubled in the past ten years, according to a new study by the Physician Insurers Association of America (PIAA). The average indemnity payment made in 1995 was $398,426, compared to an average of $211,711 in 1985 (calculated in 1995 dollars).

The study is based on information gathered from PIAA's database of more than 150,000 medical malpractice claims known as the Data Sharing Project. This resource contains detailed information on actions filed against a physician population representing approximately one-quarter of those practicing in the United States.

A recent review of the data reported between 1985 and 1995 revealed the following trends:

• In 1985, the average cost of defending a malpractice action was $6,638 ($9,300 expressed in 1995 dollars). By 1995, the cost had risen to $19,346 - more than double the adjusted 1985 cost.

• In medical malpractice cases that went to court and resulted in a verdict for the plaintiff, the average defense expense paid was $94,807, a 93 percent increase from the average expense paid in 1986, which expressed in 1995 dollars was $49,088.

• On average, of the $212,500 in indemnity and expenses incurred to compensate the "average" injured party, only about half of that amount is actually received by that party. Typically, it requires $2.00 to deliver $1.00 in compensation to the injured-party.

• Approximately $737 million was spent in 1995 to defend meritless claims.

• One of the fastest rising costs in the defense of claims is the amount paid to "expert witnesses." For claims closed in 1995, the average payment to defense experts was $3,064 or 12.3 percent of the total expense paid by a malpractice carrier for those claims reported as having an expert witness payment. By comparison, in 1985, experts received an average of $742 ($1,040 in 1995 dollars), or just 8.3 percent of the total expense paid.

"This study underlines the fact that lawyers benefit handsomely from the current malpractice system and underscores the growing requirement for expert medical opinion to refute unfounded claims," said PIAA President Lawrence Smarr. "Unfortunately, patients continue to receive only approximately 50 cents of every dollar spent to resolve malpractice claims. This waste of precious healthcare dollars is especially troubling when more than 40 million Americans currently lack health insurance."

The PIAA is a trade association of more than 50 professional liability (medical malpractice) insurance companies owned and operated by doctors and dentists.

MSMA Executive Director Announces Retirement

MSMA's Executive Director Charles (Charlie) L. Mathews announced his retirement to the Board of Trustees of the association at its December meeting. He will conclude a 35-year career with the association at the May 1998 MSMA Annual Session.

Mr. Mathews expressed "his deepest thanks for having the opportunity to serve a fine and time-honored group of people, the members of MSMA." Speaking for the Board of Trustees, its chairman, Dr. Julian C. Henderson of Jackson, acknowledged Mr. Mathews' retirement plans with "a feeling of loss, but gratitude for his long and outstanding service on behalf of the medical profession."

A graduate of Louisiana State University, Mr. Mathews became a member of the MSMA staff in 1960, serving as the association's first Assistant Executive Director and full-time government affairs staff person. He left the association in 1969 to take a position in the Governor's Office of Federal -State Programs. He later served as Deputy Director of the Mississippi Medicaid Program and then as State Commissioner of Public Welfare before returning to MSMA to become Executive Director in 1972.

Mr. Mathews served in the Army Security Agency during the Korean War. His professional and civic activities have included participation on the Board of Directors of the Mississippi Society of Medical Assistants, Boys' Club of Jackson, United Way of Jackson and the American Association of Medical Society Executives. He is a past-president of the Magnolia Little League and the Mississippi Society of Association Executives and a past chairman of the Mississippi Children's Commission.

Mr. Mathews says he looks forward to his retirement and more time for family, friends, volunteer activities and boating. He and his wife, Phoebe, have three children, Charles Jr., John and Lacy.

MSMA Presents "CPT-A Comprehensive Study"

For a great return on your educational investment, plan to attend the MSMA practice management coding workshop. In this intensive, full-day course, experienced coders will study the techniques and conventions of procedural coding. Dates and sites are as follows: January 20, 1998, Greenville; January 21, 1998-Tupelo; January 22, 1998-Jackson and January 23, 1998-Gulfport. For more information call Debra Collins, 1-800-898-0251 or (601)354-5433.

Applause, Applause for Physician-Photographers

Last year, the ***JOURNAL MSMA*** invited Mississippi physicians with an interest in photography to send in their best shots for the cover of 1998 Journals. We were enthused with the response, receiving from 85 entrees from 13 doctors across the state. Then came the overwhelming task of selecting the photos to be featured on the cover.

JOURNAL MSMA Editor Dr. Myron W. Lockey, Associate Editors Dr. Leslie E. England and Dr. Dwalia S. South, who serve on the Committee on Publications, met in December to choose the 12 they thought best represent the range of talent and creativity in portraying images of Mississippi. After almost two hours of reflection and debate, the editors selected the winning photos.

In addition to the photo by Dr. Catherine Stroud, we plan to showcase the works of physician-photographers James H. Johnson, Donald P. Brannan, Mickey P. Wallace, R. C. "Corky" Sneed, Ralph L. Brock, and Virginia Moffitt Crawford on upcoming covers. You will find a brief narrative on each photograph and the photographer in the lower, left corner of the table of contents of each issue.

We hope other physician-photographers will enter next year's contest and those who submitted entrees which were not selected will resubmit entrees.

Community Health Partners, a Physician Practice Management Company affiliated with a coalition of five regional hospitals, is seeking **Family Practitioners** and **Pediatricians** for a variety of practice opportunities in the Huntsville, Alabama area.

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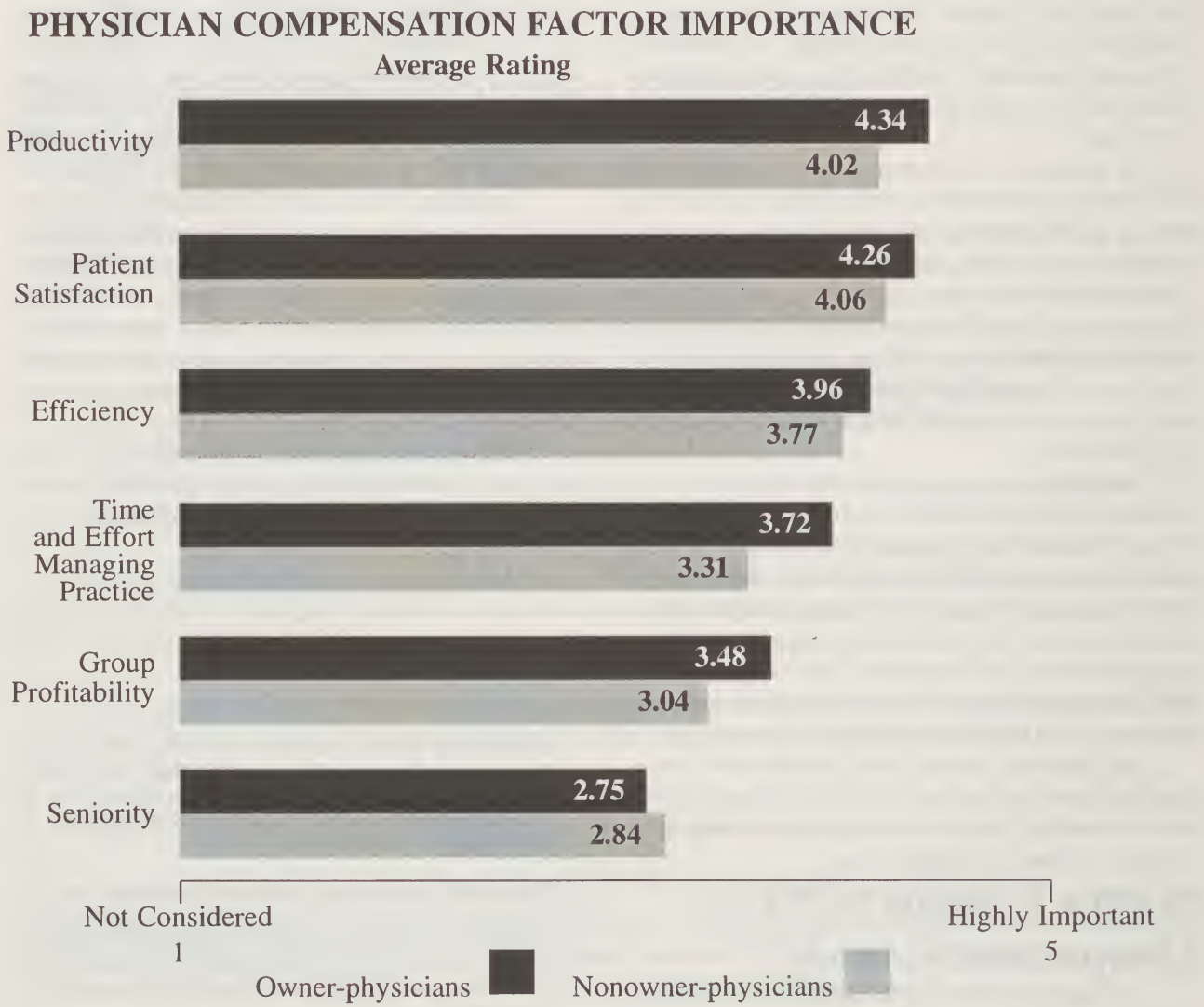
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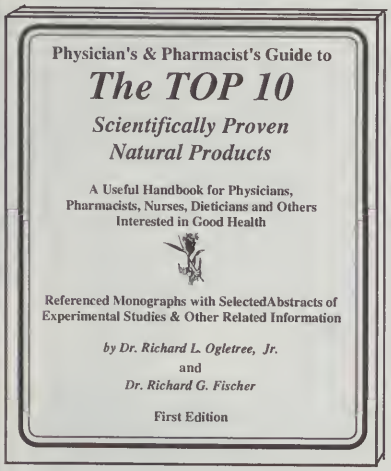
Survey Examines the Importance of Key Factors in Physician Compensation

A recent nationwide survey by the National CPA Health Care Advisors Association (HCAA) examined the factors that are considered in physician compensation. In the survey, 124 physician practices were asked to rate the importance of selected factors in determining the compensation of owner and nonowner-physicians. The results are shown below.



About HCAA

The National CPA Health Care Advisors Association (HCAA) is a not-for-profit association of CPA firms specifically selected for their experience in and commitment to serving the unique accounting, tax, and business advisory needs of health care providers. HCAA seeks to serve the health care industry by providing information through its Speakers Bureau and its surveys of members and health care practitioners.



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Ask about our 20/20 Referral Program for Doctors

Gulfport Medical Alliance got the 1997-98 year off to a great start with their major health project for the year. They jointly planned and organized a fall fashion show and brunch promoting breast cancer awareness at the Broadwater Beach Hotel in Biloxi. The event was held on Saturday morning, September 13.

The alliance worked jointly with the Southern Women's Club of Gulfport and the support of the American Cancer Society. The co-chairmen for the project were Pam Libys and Carol Reeves, health projects co-chairs for Gulfport Medical Alliance and Cathy Dumal from the Southern Women's Club.

Many hours of hard work and preparation went into this event. There were co-chairmen from each organization who jointly shared the planning and implementation of the fashion show, menu selection, speaker coordination, decorations, publicity, ticket sales, and corporate sponsorships.

The Gulfport Factory Outlet stores were excited about being a major part of the project. Off-Saks and other outlet stores provided the fashions and the gift selections for the "Mystery Boxes" that were beautifully wrapped and sold before the brunch began.

Models for the fashion show were representatives from the Coast area breast cancer survivors, Gulfport Medical Alliance and Southern Women's Club members. WLOX-TV personalities, Rhonda Weidner and Karen Abernathy were co-master of ceremonies.



Left to right: An American Cancer Society representative; Libby Murr, Southern Women's Club; Wendy Roberts, Cathy Dumal and Pam Lybis, Gulfport/Coast Medical Alliance.

Invitations were sent to various women's clubs on the Coast and the information concerning the event was put in the newspaper and on TV. Jacki Yarrington, Bay St. Louis artist, did the logo for the posters and invitations. It was representative of the theme depicting breast cancer awareness.

There were around 250 tickets sold and sponsors, both individual and corporate, were invited to be a part of the project. Memorial Hospital at Gulfport and Blue Cross-Blue Shield of Mississippi were two of the major sponsors.

The keynote speaker for the morning was Jane Hill, comedian and breast cancer survivor. Jane's major theme for her presentation is "Keep Laughing to Keep Healthy." She involved the audience in her presentation by walking through the group and talking with them about personal experiences and the importance of laughter and lightheartedness in dealing with pain and illness. The American Cancer Society had pamphlets on each table related to breast cancer and guidelines for early detection of breast cancer.

The money raised from the project will go to breast cancer research and patient care. The Gulfport Medical Alliance was proud to be a part of a project that will help make the Coast community more aware of the importance of early detection in breast cancer. It was also fun working in conjunction with another Coast women's group to make this project happen. Joining forces is a good way to share the work load and meet other women in your communities.

Breast cancer awareness is a topic worth any amount of effort. If any of you are interested in having Jane Hill speak to your group, her phone number is (714)-546-2339. **-Ann Hopper**



Gulfport/Coast Alliance Member Sharon Rodgers and her sons modeled in the fashion show.



Mary Helen Schaeffer, Immediate Past-President of the Gulfport/Coast Alliance.



Rhonda Weidner and Karen Abernathy of WLOX-TV in Biloxi were co-master of ceremonies.

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Looking Back on the Successes of 1997 and Forward to the Challenges of the Coming Year

The new year promises to be a busy, productive time at the Foundation, as the Health Care Quality Improvement Program continues to offer challenges.

The month of January leads the way as FMC staff members give presentations at the American Health Care Quality Association Technical Conference in Austin. The Atrial Fibrillation Stroke Prevention program and the Horizons Flu Project will be the topics. Also, exhibits featuring these two projects will be shown.

The Health Care Financing Administration (HCFA) is focusing nationally on specific areas of emphasis including acute myocardial infarction, diabetes and prevention projects, such as flu, pneumonia and mammography. The Foundation welcomes an opportunity to work on these vital health issues and looks forward to addressing new areas as negotiations for the Sixth Scope of Work get underway with HCFA next year.

Reviewing the past year is a positive way to make plans for even more health care quality improvement initiatives in 1998. The Foundation is extremely proud that 89 percent of the state's hospitals have participated in Health Care Quality Improvement Program (HCQIP) projects. Five physician clinics including 30 individual practitioners have participated in the new outpatient diabetes project. During 1997, the Foundation has experienced an innovative, vital year, with numerous measurements showing its importance in assuring quality and improving care for Mississippi Medicare recipients.

The Horizons program with Jackson State University's MS Urban Research Center and the Health Care Financing Administration has not only contributed to increasing the state's influenza immunization, but has also been reinforced with special recognition from the Mississippi Society of Association Executives. The Associations Advance Mississippi Award came in the form of a handsome plaque reading: "Presented to the Mississippi Foundation for Medical Care . . . Honorable Mention in recognition of outstanding contributions in community service by associations in the State of Mississippi." The awards were presented by Lt. Gov. Ronnie Musgrove at the Governor's Mansion on Nov. 6.

The Hinds County Human Resources Agency also recognized the Horizons program with a special plaque for outstanding community service.

The Mayor and City Council of the City of Jackson boosted flu immunization efforts in the Capitol area through special proclamation ceremonies at the City Hall. Mayor Harvey Johnson signed an official proclamation, and City Council President Louis Armstrong got his flu shot from Dr. James McIlwain. The cooperation of the press helped to tell the immunization story throughout the capital area as well as throughout the state.

Statewide, the general flu project has included numerous promotions, including presentations at many public sites, from shopping centers to pharmacies to grocery stores, department stores, and senior centers. State Department of Health nurses have been on hand to give shots at the various locations.

Successfully increasing awareness about the importance of flu immunizations is just one improvement resulting from HCQIP projects. Other improvements include:

1) A total of 44 hospitals are now collaborating with the Foundation on the Cooperative

Cardiovascular Project; analysis of the data has revealed noted aggregate improvement in five of the seven quality indicators. To date, collaborating hospitals for which

remeasurement has been completed represent 32 percent of the beneficiaries diagnosed with an AMI in Mississippi. Ultimately this project will have included 64 percent of beneficiaries.

2) Use of Ace Inhibitors in Heart Failure follow-up review revealed a statistically significant increase in LV ejection fraction measurement from 50.7 percent to 64.3 percent; documentation of numeric quantification of LV ejection fraction increased from 75.8 percent to 91 percent; left ventriculograms (invasive/high cost) decreased from 70.4 percent to 3.4 percent, while echocardiograms (non-invasive/lower cost) increased from 19.2 to 67 percent between baseline and follow-up.

3) In acute stroke blood pressure management, a total of 31 hospitals submitted improvement plans agreeing to educate staff and monitor compliance with the AHA guideline. Post project monitoring indicates the following aggregate improvement: orders for emergent blood pressure treatment decreased form 23.85 to 16.69 percent; the percentage of cases where sublingual nifedipine was used decreased form 80.77 to 60.38 percent.

With an 89 percent participation rate on the part of Mississippi hospitals in HCQIP projects, 1997 can surely be summed up as a busy, productive and successful year. The Foundation looks forward to continued collaboration with these hospitals and hopes to be able to claim 100 percent participation in 1998 as the work to advance the quality of health care for Mississippians continues.

NOTE: The Annual Report recently released by the Foundation reveals many more details and statistics about the projects. Anyone who did not receive one and wishes to have a copy should contact the Foundation at 601-354-0304.

The analyses upon which this article is based were performed under Contract Number 500-96-P510, entitled "Utilization and Quality Control Peer Review Organization for the State of Mississippi," sponsored by the Health Care Financing Administration (HCFA), Department of Health and Human Services. The content of this article does not necessarily reflect the views or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government. The author assumes full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care Quality Improvement Program initiated by HCFA, which has encouraged identification of quality improvement project derived from analysis of patterns of care, and therefore required no special funding on the part of this Contractor. Ideas and contributions to the author concerning experience in engaging with issues presented are welcomed.

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BLOUNT, JAMES JEFFREY, Picayune. Born Ft. Smith, AR, November 12, 1956; MD Louisiana State University School of Medicine, Shreveport, LA 1989; Ob-gyn residency, same, 1989-93; elected by Pearl River Medical Society.

BOONE, JOHN M, Jackson. Born Jackson, MS, April 15, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1991; family practice residency, same 1991-94; elected by Central Medical Society.

COBB, JAMES ROBERT, Grenada. Born Kansas City, MO, February 2, 1966; DO West Virginia School of Osteopathic Medicine, Lewisburg, WV, 1993; internal medicine residency, University of Alabama Medical Center, Birmingham, AL, 1993-97; elected by North Central Medical Society.

COOPER, KEVIN SCOTT, Pascagoula. Born Southampton, Bermuda, December 4, 1961; MD University of Iowa College of Medicine, Iowa City, IA 1988; ob-gyn residency, University of Florida Medical Center, Jacksonville, FL, 1988-90; occupational medicine fellowship, Medical College of Wisconsin, WI 1995-97; elected by Singing River Medical Society.

DEL CASTILLO-ARCEO, KATHERNY N, Durant. Born Philippines, April 3, 1965; MD University of St. Tomas Faculity of Medicine & Surgery, Manila, Philippines, 1990; interned & internal medicine residency, Metropolitan Hospital Center, New York City, NY, 1991-96; elected by North Central Medical Society.

DORAN, DONALD R, Decatur. Born W. Chester, PA, September 25, 1958; DO Philadelphia College of Osteopathic Medicine, Philadelphia, PA, 1985; family medicine residency St. Francis Family Practice, 1985-88; elected by East MS Medical Society.

EBEID, MAKRAM R, Jackson. Born Egypt, December 11, 1955; MD AinShams University Facility of Medicine, Cairo, Egypt, 1979; pediatric residency, University of Mississippi Medical Center, Jackson, MS, 1986-89; pediatric cardiology residency, University of Miami/Jackson Memorial Hospital, Miami, FL 1990-93; elected by Central Medical Society.

FAULKNER, STEPHEN BLAIR, Jackson. Born Ontario, Canada, December 10, 1952; MD University of Toronto Medical School, Canada 1976; general surgery residency, University of British Columbia, 1978-84; hepato-biliary fellowship, Hong Kong, Jan - March 1985; elected by Central Medical Society.

FERRER, JOSE LUIS, Vicksburg. Born San Juan, Puerto Rico, January 21, 1955; MD Yale University School of Medicine, New Haven, CT, 1979; orthopaedic surgery residency St. Luke's Roosevelt Medical Center, Columbia Univ., New York, NY, 1981-84 and North Shore University Hospital, Cornell Univ., New York, NY, 1979-80; pediatric orthopaedic fellowship, Alfred I DuPont Institute; elected by West MS Medical Society.

GOEL, PARVESH K, Ridgeland. Born India, December 3, 1962; MD Maulane Azad Medical College, New Delhi, India, 1984; internal medicine residency, Mount Sinai Services at Elmhurst, New York 1994-97; elected by Central Medical Society.

GORDON, FELIX, Jackson. Born in Magnolia on December 1, 1966; MD University of Arkansas School of Medicine, Little Rock, AR 1992; urology residency, same, 1992-97; elected by Central Medical Society.

HANNA, RICHARD T, Pascagoula. Born Charleston, SC, July 19, 1949; MD Medical University of South Carolina, Charleston, SC, 1976; family practice residency, Spartanburg General Hospital, Spartanburg, SC, 1976-79; elected by Singing River Medical Society.

HUBER, MIKE S, Lucedale. Born Mobile, AL, March 27, 1964; MD University of South Alabama College of Medicine, Mobile, AL, 1994; family practice residency, same, 1994-97; elected by South MS Medical Society.

KNIGHT, HAVON, Meridian. Born Laurel, MS, February 18, 1968; MD Harvard Medical School, Boston, MA 1994; internal medicine residency, Emory University Medical Center, Atlanta, GA

1994-97; elected by East MS Medical Society.

KULIK, ALICDES V, Jackson. Born Lima Peru, November 1, 1937; MD Madrid University Medical School, Madrid, Spain, 1966; psychiatry residency, Westchester Medical Center 1969-72; child & adolescent psychiatry, Long Island Jewish Hillside Medical Center, Long Island, NY, 1972-74; elected by Central Medical Society.

KULIK, FRANK A, Jackson. Born Binghamton, NY, May 26, 1938; MD University of Maryland School of Medicine, Baltimore, MD, 1967; interned one year, same; psychiatry & neurology residency, New York Medical College, New York, 1968-72; elected by Central Medical Society.

LAURO, FRANCIS J, Laurel. Born Lansdoune, PA, December 21, 1961; DO, University of Health Sciences, College of Osteopathic Medicine, Kansas City, MO, 1991; internship and internal medicine residency, Hospital Consortium of the Philadelphia College of Osteopathic Medicine, Philadelphia, PA, 1991-94; cardiology residency, Deborah Heart & Lung Center, Browns Mille, NJ, 1994-97; elected by South MS Medical Society.

LEBAS, STUART J, Hattiesburg. Born Louisiana, August 4, 1965; MD Louisiana State University School of Medicine, Shreveport, LA, 1991; internal medicine residency, same, 1991-94; pulmonary & critical care medicine, Same, 1994-97; elected by South MS Medical Society.

LEWIS, MICHAEL R, Biloxi. Born San Benito, TX, February 8, 1952; MD University of Texas Medical Branch, Galveston, TX 1978; internal medicine residency, Keesler USAF Medical Center, Biloxi, MS, 1978-82; cardiology residency, Wilford Hall USAF Medical Center, Lackland AFB, San Antonio, TX, 1982-84; elected by Coast Counties Medical Society.

LEONOVICZ, DOUGLAS, Gulfport. Born Omaha, NE, June 16, 1961; MD Creighton University School of Medicine, Omaha, NE, 1987; surgery residency Tulane University Medical Center, New Orleans, LA, 1987-92; vascular surgery residency, same, 1992-93; elected by Coast Counties Medical Society.

LIM, MIN YING, Jackson. Born Hong Kong, February 6, 1964; MD Baylor College of Medicine, Houston, TX, 1991; internal medicine residency, Beth Israel Medical Center, Manhattan, NY, 1991-94; pulmonary & critical care medicine residency, same, 1994-97; elected by Central Medical Society.

McHENRY, JACK E, II, Quitman. Born August 7, 1967; MD University of Mississippi School of Medicine, Jackson, Ms, 1994; interned one year and family practice residency, Same, 1995-97; elected by East MS Medical Society.

MORRIS, JASON K, Greenwood. Born Atlanta, GA, July 4, 1967; MD Mercer University School of Medicine, Macon, GA, 1993; diagnostic radiology residency, Baptist Memorial Hospital, Memphis, TN, 1993-97; elected by Delta Medical Society.

MUYOT, MA ROLIZA J, Ripley. Born Philippines, September 25, 1962; MD University of the East Ramon Magsaysay Memorial Medical Center, Philippines, 1988; pediatric residency, University of Illinois Medical Center, Chicago, IL 1993-96; elected by North MS Medical Society.

NOFAL, ASHRAF M, Greenville. Born Egypt, June 13, 1961; MD Faculty of Medicine, Cairo University, Cairo, Egypt pediatric residency, University of Mississippi Medical Center, Jackson, MS, 1993-96; pediatric hematology-oncology fellowship, same, 1996-97; elected by Delta Medical Society.

ODVINA, CLARITA V, Jackson. Born September 10, 1952; MD University of the East Medical School, Philippines, 1977; internal medicine residency, Loyola University/Hines, VA, Hines, IL 1989-92; endocrinology fellowship, University of Illinois College of Medicine, Chicago, IL 1992-94; elected by Central Medical Society.

PERKINS, MICHAEL W, Greenville. Born Houston, TX, December 20, 1965; MD Texas Tech University School of Medicine, Lubbock, TX, 1994; pediatric residency, same, 1994-97; elected by Delta Medical Society.

ROSS, ELAINE L, Jackson. Born Dalton, GA, February 9, 1965; MD Medical College of Georgia, Augusta, GA, 1991; ob-gyn residency, University of South Alabama Medical Center, Mobile, AL, 1991-95; maternal-fetal medicine fellowship, University of Mississippi Medical Center, Jackson, MS, 1995-97; elected by Central Medical Society.

SACKS, MATTHEW J, Gulfport. Born Brooklyn, NY, February 9, 1949; MD State University of New York School of Medicine, Stoneybrook, NY, 1971; internal medicine residency76-78; oncology

residency, Sloan Kettering Memorial Canter Center, New York 1978-80; elected by Coast Counties Medical Society.

SMITH, RANDEL L, Hattiesburg. Born Louisiana, December 14, 1962; MD Louisiana State University College of Medicine, Shreveport, LA, internal medicine residency, Same, 1991-94; cardiology residency, same, 1994-97; elected by South MS Medical Society.

TEAL, KIMBERLY C, Jackson. Born Hattiesburg, MS, May 14, 1969; MD University of Mississippi School of Medicine, Jackson, MS, 1994; internal medicine residency, same, 1994-97; elected by Central Medical Society.

WELSH, THOMAS E, Union. Born Chicago, IL, November 17, 1951; MD Medical College of Georgia, Augusta, GA, 1977; internal medicine residency, St Mary's Health Center, St Louis, MO, 1977-80; elected by East MS Medical Society.

WILSON, JAMES KEENAN, Vaiden. Born Jackson, Ms, July 2, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1994; family practice residency, Same, 19994-97; elected by North Central Medical Society.

WINN, LAUREN M, West Point. Born Summit, NJ, May 13, 1961; MD Louisiana State University School of Medicine, New Orleans, LA, 1991; ob-gyn residency, University of Rochester/Strong Memorial Hospital, Rochester, NY 1991-95; elected by Prairie Medical Society.

Larry D. Field, MD recently participated as an instructor at the Arthroscopy Association of North America clinical training session in Chicago, Illinois. He also recently participated as an instructor at the annual Arthroscopy Association of North America Scientific meeting in Nashville, TN. Dr. Field presented talks on "Wrist Portal Anatomy and Diagnostic Arthroscopy," "Miscellaneous Elbow Conditions" and "Open Versus Arthroscopic Shoulder Stabilization: Which Is Better?". He also served as a laboratory instructor in the wrist and elbow arthroscopy laboratories.

Kenneth L. Hines, MD, an Internal Medicine physician from Greenwood, Mississippi, attended the Southern Medical Association's 91st Annual Scientific Assembly, held in Charlotte, North Carolina. Dr. Hines is a 15-year member of the SMA. SMA's Annual Scientific Assembly is the latest CME meeting in the United States.

Charles S. O'Mara, MD gave a presentation at Surgical Grand Rounds at Vanderbilt Medical Center in Nashville on "Current Issues in the Management of Renal Artery Occlusive Disease."

Claude D. Brunson, MD, assistant professor of anesthesiology was elected president-elect of the Mississippi Society of Anesthesiologists. **Dr. Mahesh P. Mehta,** professor of anesthesiology was elected secretary-treasurer; and **Dr. John H. Eichhorn,** professor and chairman of anesthesiology, was elected as an alternate delegate for the American Society of Anesthesiologists. All are at the at the University Medical Center (UMC)

Paul M. Allen, M.D., F.A.C.O.G., Chief Executive Officer and Medical Director, announces that the Women's Center for Health Care in Pascagoula has been awarded a Certificate of Accreditation by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

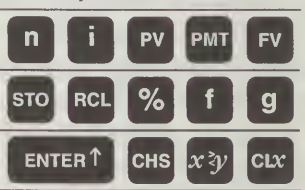
Steven E. Zachow, MD has been re-appointed to the Mississippi Radiation Advisory Council, representing the Mississippi Medical Association. This appointment is for a three (3) year term expiring August 2000. The Mississippi State Board of Health unanimously approved the re-appointment in regular session on October 8, 1997.

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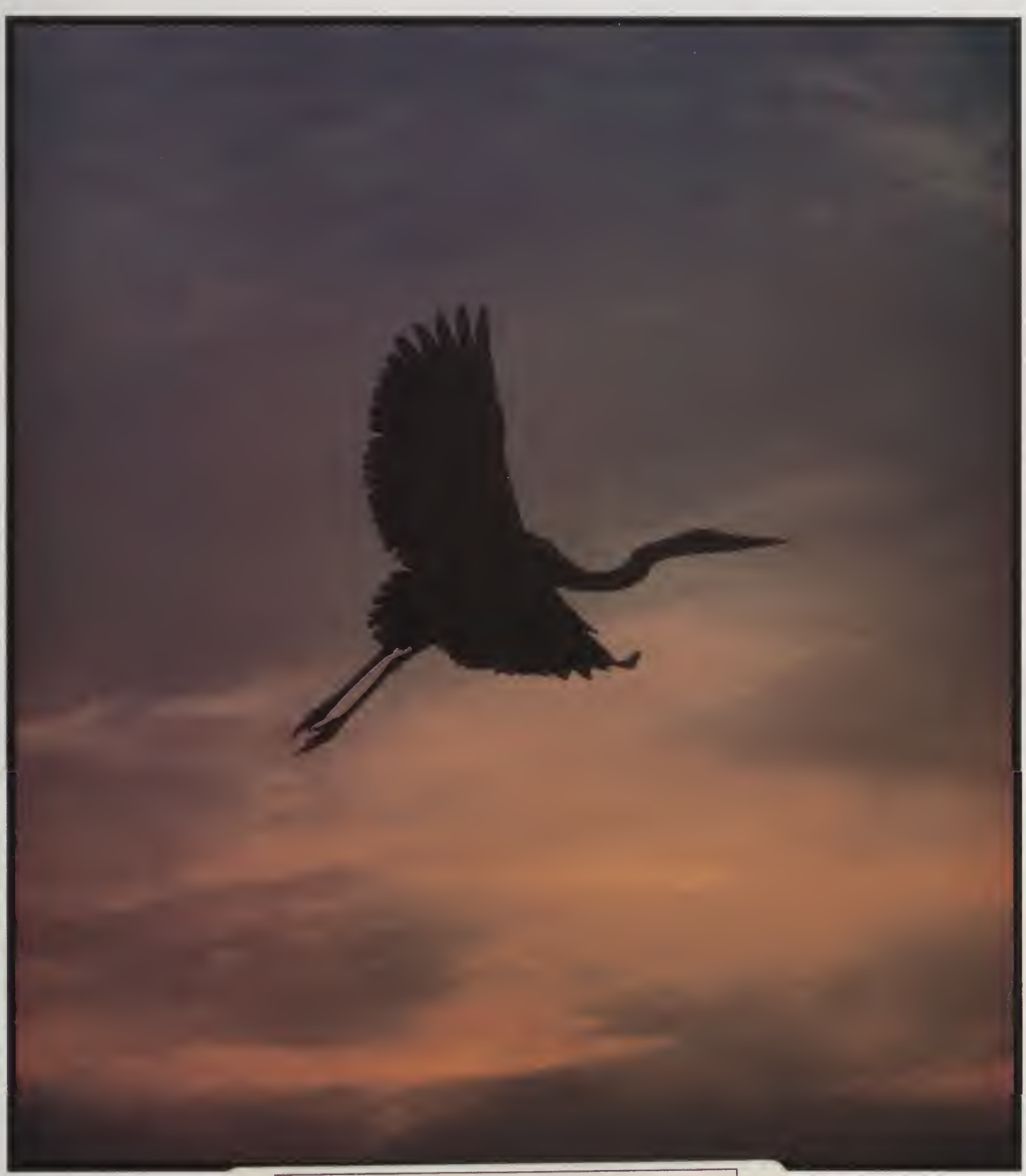
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The cover photograph of a "Great Blue Heron at Sunset" was taken by James H. Johnston, III, M.D., a gastroenterologist and internist with Gastrointestinal Associates, P.A. in Jackson. Dr. Johnston is an avid wildlife photographer, having produced the Mule Jail Hunting & Fishing Club 1998 Calendar.

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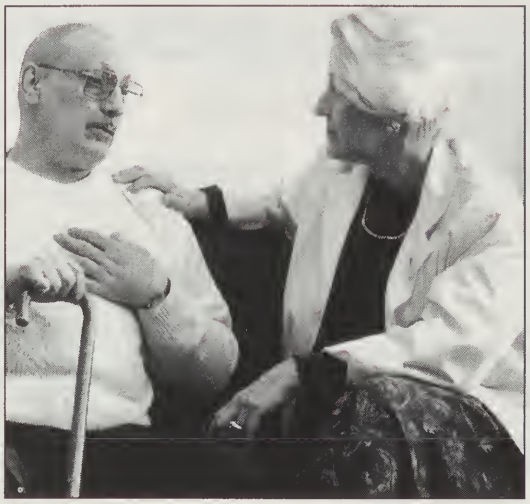
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It's time to reform Medicare. But please...



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Some very influential voices in government and the press don't think so. Here's a sampling of what they say:

Congressional Budget Office: In a 1996 report on deficit reduction, the CBO warned that with across-the-board cutting in Medicare, some beneficiaries "*...might find that they no longer had access to some medical services in the traditional fee for service sector.*"

The New York Times: In an editorial, the *Times* criticized policy makers who "*...pretend that physician reimbursements can be cut without affecting health care—as if both doctors and hospitals can be slammed without hurting anyone except the providers of care.*"

Physician Payment Review Commission: In its annual report to Congress, PPRC said the current Medicare reimbursement formula for physicians "*...will set increasingly unrealistic target rates of expenditure growth....*"

Physician cuts alone will not do the job. And the cuts that are currently proposed would actually hurt physicians by rolling back reimbursements so far that they don't even match inflation growth.

That's not fair. It's not fair to physicians, and it's not fair to patients, who ultimately pay the price under such drastic cuts.

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Comparison of Insulin Regimens and Administration Modalities in Pregnancy Complicated by Diabetes

Mitchell W. Schuster, M.D.
Suneet P. Chauhan, M.D.
Barbara N. McLaughlin, R.N., M.N.
Kenneth G. Perry, Jr., M.D.
John C. Morrison, M.D.

Abstract

Purpose: To compare insulin administration using premixed insulin (70% NPH/30% Regular) by an injectable pen with traditional self-mixed insulin administered by syringe.

Methods: In this study, 93 women were enrolled into four groups.: 1) self-mixed/syringe, 2) premixed/syringe, 3) self-mixed/pen, and 4) premixed/pen.

Results: Women in the premixed pen group had significantly less cesarean deliveries for failure to progress in labor and a decrease (not significant) in postpartum infection and infant macrosomia. Patients felt premixed insulin administered by the pen was easier to use. No significant differences were noted in glucose control, compliance among the four groups, or cost.

Conclusion: Premixed insulin administration via the pen is safe, effective and no more costly than traditional treatment for pregnant diabetic women.

Key words: Diabetes, Pregnancy, Premixed Insulin

Introduction

Rigid glucose control among diabetic patients improves the perinatal outcome.[1] Elevated maternal glucose levels in early gestation are associated with a three-fold increase in congenital anomalies.[2] Prolonged hyperglycemia during pregnancy has long been associated with abnormal growth of the fetus, intrauterine fetal demise, traumatic delivery, operative procedures, neonatal hypoglycemia, and hypocalcemia.[3] One method to reduce such adverse outcomes is to rigidly control glucose excursions by maintaining a fasting glucose less than 100 mg/dl and less than 120 mg/dl after meals.[4] The conventional method of administering insulin to pregnant women usually consists of subcutaneous injections twice daily with intermediate-acting insulin and regular insulin.[5]

The difficulty with this approach is noncompliance. Studies indicate that physicians overestimate the degree of glucose control achieved by their patients and that providers are unable to predict accurately the likelihood of individual compliance.[6] Alternatively, a continuous infusion of insulin via an external pump is recommended for the same patients who have extreme variations in glucose levels despite conventional therapy.[7] The pump, however, for the majority of patients is too costly and not required. Thus, a new method of administering insulin to diabetic patients which will improve compliance, glucose control, and obstetric outcome would be beneficial. Utilizing premixed insulin with an injectable pen is a technique which has demonstrated similar efficacy as traditional subcutaneous injections among nongravid patients.[8] There are, however, no reports regarding the use of premixed insulin with the pen in pregnancies complicated by diabetes.

The purpose of this prospective study was to assess the efficacy of this mode of administration and compare it to the glucose control obtained with conventional split-dose/self-mixed insulin therapy in pregnant women with diabetes.

Methods and Materials

Patients eligible for this study included pregnant women with insulin-dependent diabetes who initiated prenatal care at the University of Mississippi Medical Center. The study was approved by the Investigational Review Board of the University Medical Center. Inclusion criteria were insulin-dependent diabetes, maternal age 15 to 44, < 20 weeks' gestational age at entry, and willingness to sign an informed consent form.

Exclusion criteria were additional pregnancy complications which might effect maternal/infant outcome (hypertension, placenta previa, fetal malformations, and glucose intolerance not requiring insulin), unwillingness to comply with prenatal care/aggressive glucose control, and patient refusal to participate.

Women who met inclusion criteria were identified by the obstetric clinic personnel and the study was addressed by obstetric nurses trained specifically as a diabetic educator. After screening for exclusion factors, one of the physician authors were contacted and the patient was asked to sign an informed consent form after the study was explained. Randomization was carried out by selecting an opaque, consecutively-numbered envelope in which computer-generated randomization cards were placed to assign patients into one of four groups. Women in group 1 used conventional self-mixed regular and NPH insulin twice each day. Group 2 patients used premixed 70NPH/30REG insulin® (Squibb Novo, Inc., Princeton, NJ) with conventional syringes and needles as in the first group. Women in group 3 administered self-mixed split-dose regular and NPH insulin using the NovolinPen® (Squibb Novo, Inc., Princeton, NJ) twice per day. Group 4 gravidas used premixed 70/30 insulin administered in the NovolinPen®.

All subjects underwent initial evaluation of their current level of glucose control. Intensive education regarding capillary glucose home monitoring was carried out by nurse educators. During the initial assessment, ultrasound confirmation of gestational age and a survey of fetal anatomy was performed. All patients were placed on appropriate diabetic ADA diets for pregnancy based on their weight, food preference, and activity level. At each prenatal visit (two-week intervals) women were continually educated about the importance of diet, activity and insulin administration on glucose homeostasis. Each patient was assigned to one of the diabetic nurse educators and given a work and home number so that patient contact could be carried out 24 hours per day, 7 days per week if questions about glucose control were raised.

Patients performed capillary glucose monitoring each day in the fasting state as well as a two-hour postprandial assessment after breakfast, lunch, and dinner. Insulin adjustment was carried out to achieve fasting capillary glucose levels of > 60 and < 100 mg/dl and 2-hour postprandial levels of > 80 and < 130 mg/dl. Appropriate insulin adjustments were made by the house officers and approved by the obstetric staff in attendance.

Scores were assigned to each patient by these nurses at the end of each gestation that reflected overall patient compliance as demonstrated by diet assessment, adequate glucose monitoring, insulin usage, and appropriate follow-up with physician instructions and visits. The scoring system was based on a numeric 1 to 5 scale (1 = good compliance, 2 = better-than-average compliance, 3 = average compliance, 4 = worse-than-average compliance, and 5 = poor compliance).

Serial sonography were performed on all subjects beginning at 28 weeks' gestation for evaluation of interval growth. Weekly antenatal fetal health assessment tests were initiated at 32 weeks' gestation. The timing of delivery was dependent on glucose control, obstetric history, and the results of antepartum surveillance. Intravenous crystalloid solutions were administered to all patients during labor and intravenous glucose/insulin infusions were initiated on all patients whose capillary glucose monitoring was > 105 mg/dl. The mode of delivery was based on overall clinical evaluation and response to labor. House staff managing the patient were unaware of the treatment regimen to which the patient was assigned during the antepartum period.

Appropriate glucose monitoring of the infant was performed by the pediatric department. Pediatricians supervised all neonatal resuscitation and nurses assigned the Apgar scores.

The following variables were evaluated during the study: gestational age at delivery, number of prenatal visits, cesarean deliveries for arrest disorder in active phase, pregnancy-induced hypertension, preterm labor, abruption, chorioamnionitis and endometritis, maternal and neonatal hospitalization days, infant weight, macrosomia, and 1 and 5 minute Apgar scores as well as infant complications such as hyperbilirubinemia, hypocalcemia, hypoglycemia, and incidence of admission to the neonatal intensive care unit. All outpatient capillary glucose assessments performed during the preg-

Table 1. Maternal Demographics

	Group 1 SM/SYR (N = 24)	Group 2 PM/SYR (N = 24)	Group 3 SM/PEN (N = 22)	Group 4 PM/PEN (N = 23)	P
Age	27.9 ± 6.1	27.9 ± 5.7	28.2 ± 5.6	28.7 ± 5.4	NS
Parity	1.7	1.6	1.5	1.5	NS
Race					
C/AA/NA	1/21/2	2/21/1	2/19/1	34/19/1	NS
Prenatal visits	12.8 ± 7.2	13.2 ± 5.0	12.3 ± 5.5	13.9 ± 6.8	NS
White classification					
A2	10	10	9	14	NS
B,C	12	13	11	8	
D,F	2	1	2	1	

SM, self-mixed; PM, pre-mixed 70/30; SYR, syringe; PEN, NovolinPen®; C, Caucasian; AA, African-American; NA, Native American

Table 2. Antepartum Capillary Glucose Measurements (mean ± SD, mg/dL)

	Group 1 SM/SYR (N = 2660)	Group 2 PM/SYR (N = 2133)	Group 3 SM/PEN (N = 1860)	Group 4 PM/PEN (N = 3565)	P
Fasting	114.1 ± 31	96.5 ± 22.3	103.2 ± 26.2	108.5 ± 25.8	NS
Breakfast*	141.5 ± 41.9	127.4 ± 30.7	130.6 ± 33.7	130.6 ± 32.1	NS
Lunch*	148.9 ± 37.9	130.2 ± 29.2	134.6 ± 33.2	132.7 ± 27.9	NS
Dinner*	143.2 ± 43.6	134.4 ± 31	134.9 ± 34.1	132.9 ± 29.9	NS

SM, self-mixed; SYR, syringe; PM, pre-mixed 70/30; PEN, NovolinPen®; *2-hr postprandial

Table 3. Maternal and Neonatal Outcome Among the Four Groups

	Group 1 SM/SYR (N = 25)	Group 2 PM/SYR (N = 24)	Group 3 SM/PEN (N = 22)	Group 4 PM/PEN (N = 23)	P
Gestational age (wks)	37.0 ± 2.9	37.9 ± 1.9	37.6 ± 2.0	36.3 ± 4.1	NS
Abdominal delivery for CPD	7 (28%)	7 (29%)	5 (23%)	0	0.03
Infection rate	11 (44%)	6 (25%)	6 (27%)	3 (13%)	NS
Maternal hospital (days)	4.5 ± 2.8	4.4 ± 2.3	4.3 ± 2.1	3.4 ± 1.4	NS
Compliance score (1-5)	3.0 ± 1.7	3.0 ± 1.4	3.3 ± 1.4	2.3 ± 1.5	NS
Birth weight (g)	3254 ± 702	3146 ± 579	3100 ± 517	2978 ± 869	NS

SM, self-mixed; SYR, syringe; PM, pre-mixed 70/30; PEN NovolinPen®; CPD, cephalopelvic disproportion; NICU, newborn intensive care unit

nancy were also evaluated.

Statistical analysis was performed by chi-square or analysis of variance followed by Student Newman-Keul's test. $P < 0.05$ was considered significant.

Results

Of the 100 patients enrolled in the study, 93 were available for outcome analysis. Two women suffered spontaneous abortions, two underwent elective termination, and 3 were lost to follow-up. These seven women were equally distributed among the four groups (1/1/3/2). Table 1 lists the demographics of the 93 patients and their randomization into the four study groups as described. There was no significant difference in age, parity, race, number of prenatal visits, or White's classification among the groups.

The number of antepartum glucose measurements performed during this study was 10,974 with an average number of 131 measurements per patient. The group values are listed in Table 2. Analysis of variance indicates that there was no statistical significance in fasting or postprandial glucose levels among the four groups.

Table 3 reveals the maternal and neonatal outcome parameters among the four groups. There was a significant difference ($P = 0.03$) between the groups in regard to cesarean delivery performed for cephalopelvic disproportion (CPD). None of the cesarean sections performed in group 4 was for CPD while 28% of the abdominal operations in group 1 was for this indication. Abdominal delivery for other reasons such as fetal distress (3) or malpresentation (2) was equally distributed between the four groups. The incidence of maternal peripartal infection approached significance ($P = 0.06$) with a 44% incidence in group 1 and a 13% incidence in group 4. Except for two wound infections, all of the infections were related to endomyometritis.

Maternal hospital days were similar and were not significantly different between groups. The subjective compliance score revealed no statistically significant difference, although the best score was achieved in group 4. Consistently, patients in that group were more compliant in the opinion of the diabetic nurse educators. The birth weight among group 4 neonates was averaged almost 150 gm lighter than the other three groups and the difference was almost statistically significant ($P = 0.07$). There were 6 gestations complicated by fetal macrosomia (≥ 4000 gm) and none of them were in group 4 (group 1 = 3; group 2 = 2; group 3 = 1). Finally there was no significant difference between groups in the other variables (1 and 5 minute Apgar scores, incidence of pregnancy-induced hypertension, preterm labor, infant hyperbilirubinemia, and hypoglycemia).

Discussion

Traditionally, euglycemia in diabetic patients has been achieved with self-mixed insulin administered via multiple injection techniques. New modalities in glucose control include premixed insulins, insulin infusion pumps and insulin pens. Although the pumps have shown improved glycemic control in the nongravid diabetic patient, they have demonstrated no difference in glycemic control or outcome in the gravid population and they are costly.[7] Published studies have noted the ease and convenience of using the premixed insulins with insulin pens and have demonstrated similar glycemic control compared to traditional methods among nongravid patients.[7,8,9] There are, however, no reports on the efficacy of using the premixed insulins or insulin pens in pregnancies complicated by diabetes.

This prospective randomized study demonstrates the effectiveness and safety of using both premixed insulin administered by injectable pens in the management of pregnancies complicated by diabetes. Parturients managed with premixed insulin delivered via insulin pens had similar capillary glucose measurements in the fasting and postprandial state as women who received traditional methods of insulin administration. No maternal or neonatal adverse effects were noted and, in fact, there was a significant decrease in the rate of cesarean deliveries for cephalopelvic disproportion among the patients who were managed with the premixed 70/30 insulin administered with the insulin pen as opposed to traditional self-mixed insulin using syringes. While not significant, the lack of macrosomic fetuses in group 4 (premixed/pen) may account for the diminished rate of abdominal deliveries. This may be in part due to better glucose control but his hypothesis could not be confirmed by our data due to small numbers of patients. Although there was consistently lower glucoses in group 4 the differences were not significant (Table 2). In part, due to the reduced rate of abdominal delivery, there was a decrease in the rate of peripartal infection among the parturients who used the premixed insulin with the insulin pen.

The cost of the NovolinPen® ($39) with premixed insulin is similar to using the disposable syringes ($36). There is no difference in the cost of insulin (cartridges versus conventional vials) in the cost per injection (10 cents with the pen versus 7 cents using the syringe). Cost aside, one of the benefits of premixed insulin with the NovolinPen® appears to be increased compliance and ease of administration. The diabetic nurse educators subjectively noted that almost all patients were very

receptive to the use of premixed insulin in the NovolinPen® as they found this system more convenient and easier to use. This supports the National Lifestyle and Experience Survey conducted on 7792 nongravid patients using this technology.[10] After using the NovolinPen® for one year, over 80% of the diabetics surveyed preferred to continue using this delivery system.[10]

In summary, this prospective randomized study indicates premixed insulin delivered with an insulin pen is safe and efficacious in managing pregnancies complicated by diabetes. This new system is simple to teach and administer. A benefit of using premixed insulin and the NovolinPen® compared to the self-mixed insulins in traditional syringes in our study was a significant decrease in abdominal delivery due to arrest disorder in the active phase of labor. A larger study will be required to demonstrate potential significant improvement in glycemic control and substantial reduction in birth weight using this system of insulin administration.

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CASE RECORDS OF THE DEPARTMENT OF MEDICINE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

CLINICOPATHOLOGIC CONFERENCE XIX

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Radiological Findings: Mark Gunn, M.D.

CASE PRESENTATION

The patient is a 22 year old black male admitted in July, 1994. He developed fatigue, weakness, and bilateral knee effusions and was evaluated by his local doctor in May, 1994, who told him he had fluid on his knees and prescribed Bactrim. He subsequently developed arthralgias in his knees, ankles, and writs with swelling, but no redness nor heat. He complained of intermittent joint pain that would last about three days, then spontaneously remit. He also reported a papular rash over his thighs and axillae with some itching. This resolved after one week. He then noted fever with night sweats but no chills. Over a two month period of time he lost 35 pounds. He was admitted to an outside hospital from May 30 to June 15, where he received cefuroxime and cefotaxime. His fever remitted with administration of azithromycin. He remained afebrile for one week, then his fever recurred; however, he did not seek medical attention again until July 8, 1994. He developed lower extremity edema and intermittent bouts of diarrhea. He was transferred to University Medical Center for further workup of his fever of unknown origin after a workup by his local doctor was negative.

Workup at the outside hospital was extensive and some not contributory. Some of the positives included a sed rate of 95, his ACE level was elevated, and his Legionella titer was 1:64. He had a bone scan which was negative. A CT of his chest and abdomen revealed several 1cm hilar nodes, and no lung masses. There was some slight splenomegaly. A thoracentesis was performed. It showed a protein of 1.9g/dl, an LDH of 1205, and a glucose of 110. His red cell count was 2307 and white cell count was 723 with 93% segs and 7% lymphs. Cultures were negative for tuberculosis and fungi. He had a fiberoptic bronchoscopy which showed inflammation with friable mucosa. Washings were taken and were negative for tuberculosis and fungal organisms. A bone marrow was performed which showed myeloid hyperplasia. He had a lymph node biopsy of a right axillary node. It showed reactive cells. There were no atypical cells and cultures performed on that node were negative.

His past medical history: none prior to current illness. His medications on transfer were Lomotil and Ciprofloxacin. He had no past surgical history. He has no allergies. Family history was positive for hypertension; otherwise was negative. Social history: occasional tobacco and alcohol use. His occupation was truck driver.

His physical examination on arrival to UMC revealed a temperature of 98.8 , his pulse was somewhat tachycardic at 110, his respiration was 20, and his blood pressure was 128/64. Generally, he was a well developed, well nourished, white male in mild respiratory distress. He was alert and oriented. HEENT: essentially benign, and his conjunctiva were pink. His neck showed no JCF and no thyroid mass. There was a right carotid bruit that was heard. He had no axillary or cervical nodes. His chest showed some decreased breath sounds and rales bilaterally at the bases, but there were no wheezes. Cardiovascular showed he was tachycardic. He did have a rub. There was so S3 heard. His liver was approximately 16cm below the left costal margin, but the spleen was not palpated. There were no masses palpated but a fluid wave was felt. His GU was normal. His extremities reveled no cyanosis nor clubbing. He had a 2+ edema bilaterally to the mid thighs. He had no synovitis, no erythema, or swelling in any joints. There were no tender points at tendon insertion sites. Neurologically, the cranial nerves were all intact. His motor exam had 4+ strength in all his distal extremities, 3+ at the should girdle bilaterally, and 3+ in his hip muscle strength bilaterally. He had a negative Babinski and sensation was intact. His deep tendon reflexes were 2+ and equal.

His admission laboratory showed an elevated white count at 19.8, H and H was 9 and 27.9, a platelets were 155. His MCV was low at 76.2. His RDW was high at 19.5. The diff showed 73% segs , 20% bands, 9 lymphs, and 1 monocyte. His electrolytes were essentially normal. He did have an acid of 3.4, his bicarb was 30. His BUN and creatinine was 22 and .5. His glucose was 101. His sed rate was elevated at 79. His protein and albumin were decreased at 5.1 and 2.2. His alk phos was elevated

at 217, his total bili was 1.2, his unconjugated was .49, and his delta bili was .71. His LDH was elevated at 1691 and his CK was < 20. His GGT was also elevated at 472. AST and ALT were 118 and 114 respectively. His PT was 13.4 and his PTT was 25.6. His compliment levels were all within normal limits. ANA was negative. His anti double stranded DNA was negative. His rheumatoid factor and HIV were negative. Fibrinogen was 260.

Some ABGs were obtained because of his mild respiratory distress. The pH was 7.53, his Pa02 was 57, PaC02 was 35, and his base excess was 7.5. A urinalysis showed a pH of 6 and a specific gravity of 1.016. It was negative for glucose, ketones, blood, and protein. He had a urine bili icto test that was positive. Microscopy was negative. Chest x-ray showed an enlarged heart with pulmonary vascular congestion. There was some alveolar infiltrate in the right mid lung field, and fluid in both costophrenic angles. His EKG showed sinus tachycardia with normal axis and intervals.

He was admitted for a workup of his fever of unknown origin. Because of the adenopathy seen on prior chest CT, a CT of the chest was repeated. It revealed bilateral pleural effusion, a moderate pericardial effusion with moderate cardiomegaly, and bilateral infiltrates, greatest in the peripheral and basilar regions. Also noted was a right paratracheal node, approximately 3.25 x 2.5cm and some right hilar adenopathy. There were also a few diaphragmatic lymph nodes, the largest measuring about 1 cm. The liver and spleen were also enlarged.

The patient had spiking fevers up to 102. Sputums were collected and were negative for tuberculosis and fungi. An echocardiogram was obtained which showed normal left ventricular size and function, trace tricuspid and pulmonic regurgitation, normal right ventricular ejection fraction, and a small pericardial effusion.

***Dr. Gunn*:** The chest x-ray on admission showed that the cardiac silhouette was enlarged. There was pulmonary vascular congestion and there was also thought to be small bilateral pleural effusions. The CT obtained the day after admission showed abnormal soft tissue density int he right peritracheal region, which was favored to represent adenopathy. The heart appeared to be slightly enlarged and there was pericardial fluid. The lung window showed bilateral infiltrates in the perihilar and the lung bases. The liver and spleen were homogenous; there was no nodularity. A later chest film showed that the heart had increased in size and was a little more globular in shape. The lung fields had improved, but there was still some interstitial disease in the lung bases and finding were suggestive of bilateral pleural effusions. A follow-up CT showed an increase in the size of the pericardial effusions and pleural effusions.

Dr. Isaacs: The case under discussion is that of a 22 year old African American male with multi-organ dysfunction. Prior to discussing the differential diagnosis, the pertinent history and laboratory findings will be reviewed briefly.

Approximately three months prior to admission the patient developed self-limited inflammatory arthritis affecting both knee joints and which was followed by symmetrical, transient arthralgias affecting large weight bearing joints. A pruritic, papular rash resolved spontaneously after approximately one week's duration. He had persistent fever and review of his temperature chart reveals a hectic pattern with temperature peaks as high as 40.5 C. He reported, in addition, peripheral edema, intermittent diarrhea, and an unexplained 35 pound weight loss over a two month period. At the time of admission he was taking Lomotil and Ciprofloxacin but he had previously taken a number of medications. There was no history of illicit drug use. He was a truck driver who had not travelled extensively out of Mississippi and whose most westward travel had been to East Texas. Physical examination revealed hepatosplenomegaly, pleural effusion, ascites, proximal muscle weakness, and no obvious site of an infection.

Radiographic studies revealed mediastinal lymphadenopathy; it is probable that there was more generalized adenopathy because a right axillary lymph node biopsy was undertaken. Bronchoscopy, performed because of hypoxemia and because of alveolar infiltrates on chest radiograph, demonstrated friable mucosa but was otherwise noncontributory. Pleuritis and pericarditis were evidenced by fluid collections in the pleural and pericardial spaces, respectively. The size of the pericardial effusion was increasing based upon serial CT chest examinations.

A multitude of laboratory studies were performed. The results are consistent with a systemic inflammatory response as evidenced by a neutrophilic leukocytosis with shift to the left in the granulocyte series, bone marrow examination showing myeloid hyperplasia, hypoalbuminemia, anemia (presumably of chronic disease but not all parameters are present for confirmation), and elevated ESR. Alkaline phosphatase and AST were mildly increased. The remaining studies were essentially noncontributory. In particular, there was no evidence of an active urinary sediment, antinuclear (ANA) and anti-double stranded DNA (anti-dsDNA) antibodies were absent, rheumatoid factor was not detected, and human

immunodeficiency virus (HIV) antibody testing was nonreactive.

In summary, this young man had a systemic disease of which the dominant features were fever, weight loss, pleuritis, pericarditis, pneumonitis, hepatitis, and transient rheumatologic involvement, initially as arthritis and subsequently as arthralgias.

Although it has been stated for many years that the normal temperature for an adult is 37.0 C, recent studies by Mackowiak *et al.* have placed this degree of precision in doubt.[1] In a study of 148 healthy middle-aged men and women attending a clinic in Baltimore, the mean temperature for the population was 36.8 C but there was a diurnal variation in body temperature ranging from 37.2 C in the morning to 37.7 C in the afternoon. Despite this debate as to what constitutes normal body temperature, there is no doubt that our patient has significant fever, and indeed given the extensive investigations undertaken, that he has fever of unknown origin (FUO).

Petersdorf and Beeson[2] defined FUO in 1961 as an illness lasting more than three weeks with a documented fever greater than 38.3 C on several occasions, and the lack of a diagnosis after one week of inpatient investigation. In more recent times, Durack *et al.* have refined this original concept to take into account the extensive use of outpatient investigations by changing one week of inpatient studies to three days of hospital investigation or three outpatient visits.[3] In addition, they proposed that as well as "classical" FUO, FUO should be subdivided into nosocomial, neutropenia-associated, and HIV-associated FUO.[3] Despite these "rigid" case definitions, it is important to retain flexibility in managing individual patients; the key elements are that fever is documented for a prolonged time and that the cause of the fever remains obscure despite numerous investigations.

It is important to have a concept of the spectrum of disease causing FUO in order to develop a rational plan to investigate such patients. Data from three representative series of FUO patients undertaken in three different decades are shown in Table 1.[4] The causes of FUO can be divided into four groups: (a) infectious etiologies, (b) "collagen-vascular" diseases which includes vasculitis and autoimmune diseases, (c) neoplasia, and (d) miscellaneous conditions. In some patients, the cause of their FUO remains unknown. Over the last forty years, infections and neoplasia appear to have assumed a declining role as we have recognized new pathogens and diagnostic techniques have improved. This gap has been filled only partially by "collagen-vascular" disorders with an increasing proportion of patients remaining undiagnosed.

Table 1. *FUO in adults (after Gelfand & Wolff, 1995)*[4]

Table 1. FUO in adults (after Gelfand & Wolff, 1995)[4]

Dates of Study	Established Causes (%)				
	Infections	Collagen-vascular	Neoplasia	Miscellaneous	Unknown
1952-57	36	13	19	25	7
1969-76	37	19	31	8	5
1980-89	23	21	7	26	23

Diagnosis of the patient with FUO requires a logical, systematic approach. A complete, detailed history and thorough physical examination form the foundation for subsequent investigations. These should be repeated frequently during the course of the patient's illness. Features of the history which need particular emphasis include a detailed analysis of occupation (e.g., occupational hypersensitivity pneumonitis can present with nocturnal fever), of travel, both within the United States and exotic travel, (e.g., exposure to *Coccidioides immitis* in south Texas), of HIV risk factors, and of potential tick exposure (e.g., Lyme disease, human granulocytic ehrlichiosis, Rocky Mountain spotted fever). A complete and thorough eye examination, including examination of the fundus following pharmacologic dilation of the pupil, is very important; for example, such an examination may make the diagnosis of endocarditis (e.g., subconjunctival hemorrhages, Roth spots), tuberculosis (e.g., retinal tubercles), or fungal disease.

Diagnosis of an infectious etiology often relies upon culture. Specimens should be obtained from any available site and should include sputum, urine, and blood in all patients. Any clinically infected site or any biopsied material should be cultured appropriately. Specimens should be submitted for routine, mycobacterial, fungal, and viral studies. Bone marrow examination, both microbiological and histopathological, should be considered in the majority, if not all, patients with FUO. The role of liver biopsy is less well defined and it is not my practice to obtain routine liver biopsy. In some instances, serological studies may be the only tests available to diagnose a number of conditions including syphilis, Lyme borreliosis, Q-fever, psittacosis, or Legionnaire's disease; it is important to note, however, that a single result is rarely diagnostic and paired sera are required to evaluate for a rise or fall in titer.

Over the past decade, radiology has become increasingly important in the evaluation of patients with

FUO. Not only do ultrasound, CT scan, and MRI prove useful for noninvasive imaging, but guided biopsy has become an indispensable tool. As a consequence, laparotomy or laparoscopy is now infrequently used for "blind" diagnostic FUO evaluations.

In summary, evaluation of the patient with FUO is the combination of detailed history and physical examination combined with an extensive laboratory and radiographic evaluation; these evaluations are to a large extent guided by abnormalities identified during examination of the patient.

There are three potential diagnoses which should always be considered in the patient with FUO: (1) drug fever, (2) factitious fever, and (3) exaggerated circadian rhythm. Exaggerated circadian rhythm[4] is a rare diagnosis in which the normal diurnal temperature variation is so pronounced that body temperature, particularly when measured in the afternoon, is elevated into the febrile range; such patients have no illness and require no treatment. None of these diagnoses seem likely in our patient.

Let us see if we can establish the cause of our patient's illness by reviewing causes of FUO in a systematic manner. First, infectious etiologies include bacterial, mycobacterial, viral, fungal, and parasitic agents. Clinically occult bacterial infections include abscesses (e.g., subphrenic abscess), pyelonephritis (e.g., in the setting of a complete ureteric obstruction), osteomyelitis (e.g., lumbar osteomyelitis in elderly men), infective endocarditis either due to fastidious organisms (e.g., the HACEK group of pathogens[4]) or non-cultivatable organisms (e.g., *Coxiella burnetii*), or obstructive biliary disease. The extensive radiographic evaluation of this patient has excluded most occult bacterial infections and it is unlikely that he has culture-negative endocarditis because of advances made in blood culture techniques over the last decade. There is no occupational or travel history to suggest *C. burnetii*.

Mycobacterial diseases, primarily tuberculosis, always need to be considered. In this patient, however, the absence of typical granulomatous changes in the lymph node biopsy makes this an unlikely diagnosis. Viral etiologies would include syndromes caused by Epstein Barr virus, cytomegalovirus, hepatitis A, hepatitis B, hepatitis C, and HIV; the patient has only minor biochemical liver function disturbance and his HIV antibody test was nonreactive.

Systemic fungal infections are seen both in immunocompetent and immunodeficient patients. Our patient has no apparent immunodeficiency state and this significantly limits the possible fungal pathogens to include cryptococcosis, coccidioidomycosis, histoplasmosis, and blastomycosis. The patient had not travelled to areas endemic for coccidioidomycosis, and although he lives in an area with endemic histoplasmosis and blastomycosis, the clinical presentation would be unusual.

Other infections which may be considered but are unlikely in our patient include malaria, toxoplasmosis, Whipple's diseases, rheumatic fever, syphilis, Rocky Mountain spotted fever, psittacosis, and cat scratch fever.

Second, although any tumor can be associated with fever, the commonest malignancy is lymphoma, and in particular Hodgkin's disease. Leukemia can also present as an FUO. Fever can be seen with any solid organ tumor but the classically described associations are with renal cell carcinoma, hepatoma, and atrial myxoma. Neoplasia remains a consideration in this patient because of lymphadenopathy but is less likely because of the negative histology from the node biopsy.

Third, fever is not an uncommon presentation for the patient with vasculitis and is most commonly seen in patients with systemic lupus erythematosus (SLE). SLE has a strong sex bias being most common in women of child-bearing age. The absence of ANA and anti-dsDNA antibodies makes SLE an unlikely diagnosis. Hypersensitivity vasculitis or leukocytoclastic vasculitis is another possibility and cannot be excluded completely on the basis of the information at hand; conversely, however, there are no specific features which would suggest this diagnosis. Rheumatoid arthritis rarely presents with fever in isolation from other manifestations. In distinct contrast, adult-onset Still's disease presents commonly with fever without overt joint manifestations; the full clinical spectrum will be discussed later. Giant cell arteritis would be an important consideration in an older patient but not in a 22 year old man.

Fourth, miscellaneous causes of FUO include sarcoidosis, inflammatory bowel disease, particularly Crohn's disease, chronic pulmonary embolism, mucocutaneous lymph node syndrome, familial Mediterranean fever, and granulomatous hepatitis. Of these conditions, sarcoid must remain a consideration because of the generalized lymphadenopathy.

After reviewing the potential explanations for FUO, adult-onset Still's disease, lymphoma, and sarcoidosis would be the top potential diagnoses. Given that the lymph node biopsy was non-diagnostic, adult-onset Still's disease would be my diagnosis. Juvenile chronic arthritis was first reported by Cornil in 1864 but is now referred to by the eponymous title of Still's disease following Still's report of a series of patients with juvenile chronic arthritis in 1896.[5] In 1971, Bywaters reported 14 cases of

juvenile chronic arthritis presenting in adults and suggested the name adult-onset Still's disease.[6]

Adult-onset Still's disease is a rare disease which has no sex bias.[7] Most patients present between the ages of 16 and 35 years and arthritis and/or arthralgias are a common manifestation. Significant fever is very common occurring in >97% of patients.[7] The rash seen in juvenile chronic arthritis is also described in approximately 88% of adult-onset Still's disease[7]; this rash is salmon pink, macular or maculopapular, evanescent, sometimes pruritic and is usually seen on the trunk and proximal extremities. Other clinical manifestations include weight loss, lymphadenopathy, splenomegaly, hepatomegaly, pleuritis, pericarditis, and pneumonitis. The full set of clinical feature are rarely present at the time of presentation, but tend to evolve over time as they did in our patient. There is no definitive confirmatory laboratory test but common findings are elevated ESR, hypoalbuminemia, anemia of chronic disease, leukocytosis greater than 15,000 per mm^3, mild derangement of biochemical liver function, negative rheumatoid factor, negative ANA, and normal or elevated complement levels.

Diagnosis: A set of diagnostic criteria have been proposed (Table 2).[7,8] The patient under discussion meets all the mandatory criteria and all the minor criteria if we accept that the rash he described was consistent with the rash of Still's disease. As stated before, the diagnoses of sarcoid and lymphoma cannot be completely excluded, but I believe that this young man has adult-onset Still's disease.

NATIONAL HIV TELEPHONE CONSULTATION SERVICE
"Warmline" (800-933-3413)

Based at San Francisco General Hospital, the "Warmline" provides free HIV clinical information and case consultation to health care providers. The Warmline faculty includes physicians, clinical pharmacists, and nurse practitioners who have extensive experience treating patients with HIV disease. Warmline consultants are available to answer questions between 7:30 am and 5:00 pm PST. A twenty-four hour voice mail system is available at other times. The Warmline is funded by the Health Resources and Services Administration, the AIDS Education and Training Centers, and the American Academy of Family Physicians.

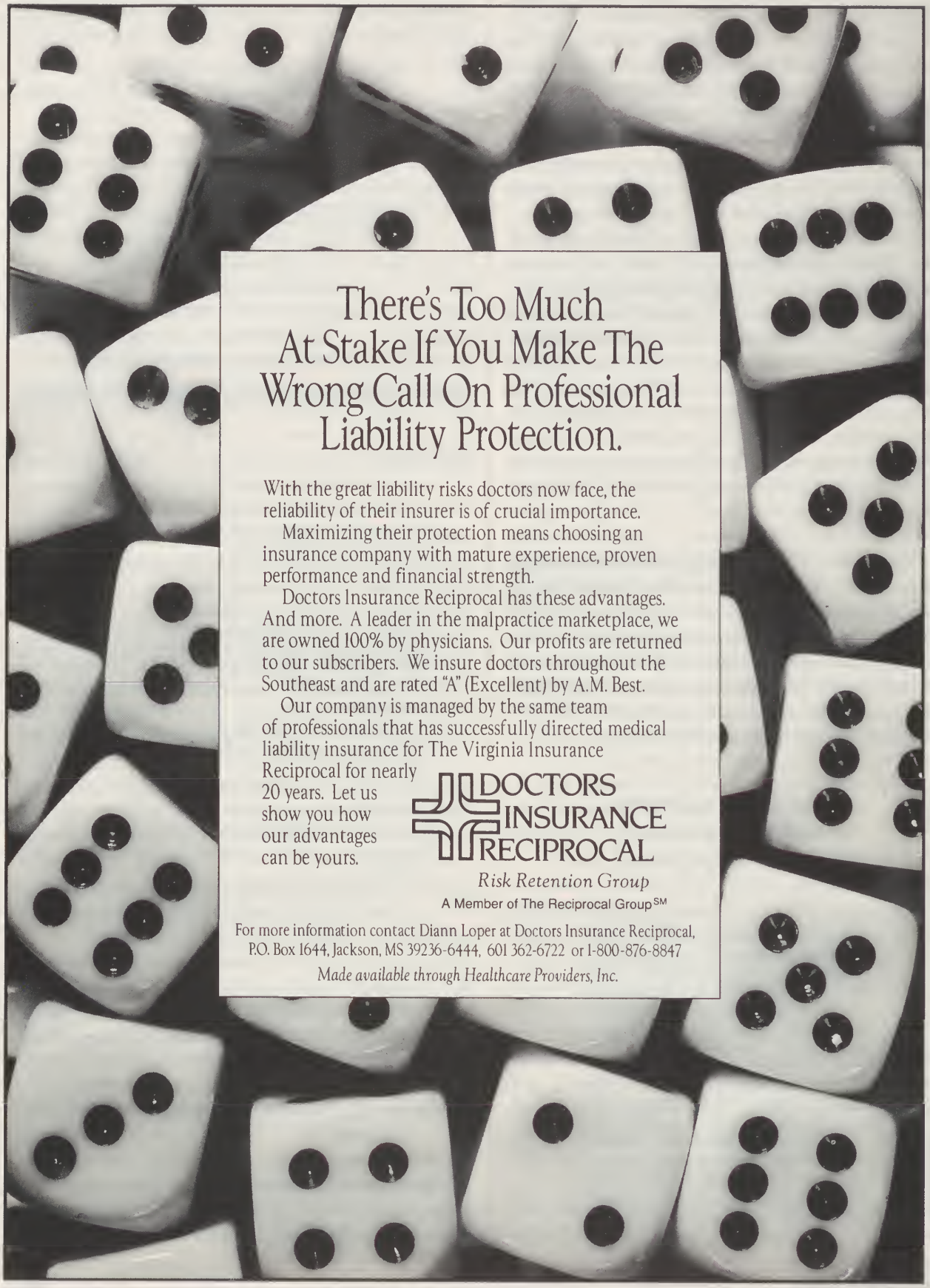
Table 2. Diagnostic criteria for adult-onset Still's disease (after Esdaile JM, 1994 and Cush JJ et al., *1987)*[7,8]

(1) All of the following
(a) fever 39 C (b) arthralgias or arthritis (c) rheumatoid factor < 1:80 (d) ANA < 1:100
(2) plus any two of the following
(1) WBC 15,000 cells/mm^3 (2) Still's rash (3) pleuritis or pericarditis (4) hepatomegaly or splenomegaly or generalized lymphadenopathy

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***Dr. Gunn** was a Resident in the Department of Radiology and*
***Dr. Subramony** is an Associate Professor of Pathology.*
***Drs. Kubiak and Daly** were Chief Medicine Residents in the Department of Medicine at the University Medical Center in 1995-1996.*



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H. Vann Craig, M.D.

The President's Page

Live and Then Give

There are over 55,000 people on waiting lists for organ transplants in the United States. This year 4,000 of those individuals will die because there is no donor for them. At the Interim meeting of the AMA, the Texas Medical Association presented their very successful organ procurement program and asked the AMA to encourage organ donation. The House of Delegates adopted this program.

The program stresses several points. If you choose to be a donor, discuss this with your family. Families frequently reverse a driver's license donor status because the subject has not been discussed and they are not sure if the card is true. The discussion of brain death and the discussion of organ donation should occur at separate times. The death of a loved one needs an adjustment period.

The program is directed toward physicians, their families, physicians' employees, and their families. Why this group? They are the most knowledgeable about the need for organ donation and you have to start somewhere! If we, the Medical Profession, can lead the way by our example, others may follow and end the shortage of organs for transplantation.

I'm an organ donor. Are you?

Vann

P.S. Don't forget to make plans to attend the AMA Leadership Conference in Washington, D.C. March 8 - 11. Check with MSMA for details.

Nomination
1998 Community Service Award

The **Annual Physician Award for Community Service,** sponsored by Mississippi State Medical Association is designed to provide recognition to members of the association who are actively engaged in the practice of medicine, for the many and varied services above and beyond the call of duty which they render to their respective communities.

Each recipient of the award is nominated by his or her component society and selection is made by the members of the Council on Public Information. The intent of the program is to honor only living persons, and to honor no person more than once. Presentation is made at the annual meeting of the association's House of Delegates. Every society has many members worthy of this distinguished award. It is your society's responsibility to see that they are nominated. **All nominations should be submitted to the Mississippi State Medical Association by February 26, 1998.**

The award is a handsome plaque which features a cast bronze medallion. The medallion's design symbolizes the close relationship between medicine and the community. **A $500 contribution** is also made by the association to a civic organization designated by the award recipient.

Nominations should be submitted in writing. There is no particular form required in this regard; however, since the award is for outstanding community service it is important that all accomplishments of the nominee in this regard be presented in detail. The Council on Public Information encourages you to seek the assistance of the your local MSMA Alliance in preparing the written nomination and supporting materials.

Nomination supporting documents may include all or some of the following: a narrative about the person and his community involvement, newspaper clippings, letters of support from community leaders, newspaper or magazine articles written about the person, photographs and other materials that show the persons community involvement.

Nominations should be sent to MSMA, P.O. Box 5229, Jackson, MS 39296-5229, as soon as possible but no later than February 26, 1998. For further information please contact: Karen Evers, Director of Communications, (601) 354-5433 or 1-800-898-0251.

Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXIX, NUMBER 2
FEBRUARY 1998

A New Number Game

I had just completed my last editorial, "Inappropriate Use of DEA Numbers," ***Journal of the Mississippi State Medical Association,*** November, 1997, vol. 38, no. 11, page 425, when I encountered another, and different, request for a number. In a telephone conversation with the precertification reviewer of an insurance company my secretary was ask for my Tax ID number, and told that it was necessary for precertification of the patient. She immediately called me to the telephone to verify the request. I was told by the reviewer that the company required my Tax ID number for precertification. I refused the request as totally inappropriate, and that this represented an unwarranted use of my personal Tax ID number. After a lengthy discussion, and the other party taking several breaks "to talk with a superior," the patient was precertified.

This request reflects yet another decision by "corporate medicine" that is grossly intrusive, extremely abusive, inappropriate, and outright rude. The large companies in what I call "corporate medicine" have assumed the attitude that they can do anything they please, anytime they want to, and have to answer to no one.

A thorough review of Mississippi law and regulations relating to precertification and utilization review do not in any language require a physician to supply any type of number when precertifying a patient, or during utilization review.

My Tax ID number is a very personal number assigned by the Internal Revenue Service for use in matters relating to billing, and reporting of my personal financial matters. It has no other purpose. Specifically, it is not a general government identification number. Like the DEA number, it was issued by a federal agency for use in matters relating to that agency only.

This abuse of power can only be controlled if physicians resist such abuses. I strongly suspect that many physicians have no idea what information is going out of their office to outside parties, and yet the physician is responsible for everything that does go out, and for any activity relating to a number assigned to the physician.

-Myron W. Lockey, M.D.
Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

Letter to the Editor Re: DEA #s

Dear Dr. Lockey:

You are EXACTLY RIGHT! I HATE to write my DEA # for antibiotics and other non-controlled medicines.

I also feel that we are not able to practice "compassionate medicine" (relieving pain and suffering, etc.) for fear that the Medical Board of Licensure and/or the DEA will monitor and punish us.

Keep up the good work.

Sincerely,

Walter C. Gough, M.D.

New Confirmed Toxicities of Dioxins "Greatest Threat to Public Health"

The MSMA House of Delegates on May 19, 1991 adopted Resolution No. 3 on "Medical Aspects of Waste Disposal."

This Resolution is still valid but in the past six years much more has been learned about the toxicity of organochlorines.

The recently released Draft of the Assessment of Dioxins and Related Compounds by the EPA and the innumerable worldwide studies of these compounds have revealed toxicity at levels much lower than previously believed. Damage to the fetus during critical developmental stages can result in slowed physical and mental development, damage to the reproductive system, the immune system and other systems. These findings have evoked comments by authorities such as "sobering"[1], "greatest threat to public health"[2], "we have poisoned our environment"[3], "permanent and devastating effects"[4], "no safe level"[5], "much more toxic than previously thought"[6].

The toxic effects of dioxins on the fetus are of special importance to pediatricians. Damage to offspring occurs with no symptoms of toxicity in the mother[7]. Some effects are not evident until adolescence. Fetal damage may result in death.

Dioxins, furans and PCB's comprise a large group of chemicals that share the same pathway into the body and produce similar toxic effects. They are commonly called "dioxins." They are mainly produced by incineration of waste (highest levels from hospital waste), the manufacturing of chlorine containing chemicals, metallurgy, and the bleaching of wood pulp by paper mills. Ninety percent of dioxins enter the body in foods, mainly from meats and dairy products. We all carry a body burden of dioxin, stored in our fat and not excreted except during pregnancy and lactation.

Effects of dioxins on the body:

A. Cancer: Dioxins have now been shown to be a multi-site, multisex and multispecies carcinogen in humans.[8] The carcinogenic effect requires higher body levels of dioxins than the newly confirmed non-cancer effects.

B. Non-cancer effects: Primarily these result from damage to the fetus and newborn from dioxins transmitted from the mother.

1. The immune system:

"Dioxin exposure increases susceptibility to bacteria (salmonella, typhoid, E. coli endotoxin and pneumococci), viruses (herpes simplex, influenza), parasites (malaria, trichinella) and transplanted tumors."[9]

2. The reproductive system:

In the male--testicular cancer - 3-4 times higher in the past 50 years in the U.S.; sperm count - 50% decreased in the past 50 years; cryptorchism and urethral abnormalities increasing; prostate cancer - doubled in the past 10 years due to synthetic hormones during fetal development.[10]

Other findings: hypospadias increased, abnormalities of the external genitalia (shorter penises[11]) and delayed puberty; also reduced androgen levels causing demasculinization (feminization).[12]

In the female dioxins cause diminished fertility, increased incidence of endometriosis, breast cancer increase of 1% per year for the past 50 years, and premature menarche.[13]

3. The Ectodermal system:

Ectodermal dysplasia involving skin, nails, teeth and gums.[14]

4. Development

Slowed physical and mental development.[15]

The comments expressed in this Journal are those of the indicated author. Comments and opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit comments for publication regarding any opinion expressed or information contained in the Journal.

CONCLUSIONS:

1. The present body levels of dioxins are currently at or near the level to produce adverse effects. The fetus and newborn may now be at risk.[15]

2. According to the EPA, the dose (of dioxins) below which no adverse effects are likely to occur would be "10 to 100 times below the current estimates of daily intake in the general population."[16]

3. "Fetuses and children should be the threshold for regulating toxic substances."[15]

4. "The debate over how to define a safe level of exposure to dioxin has become irrelevant...Dioxins clearly pose a public health hazard now and the EPA's (draft) report serves as a call to action ...The present patchwork of regulation for dioxin provides inconsistent and inadequate protection."[16]

5. "Harmful effects on wildlife (fish, birds and animals) have been known for 40 years. It is now being recognized that similar effects are affecting humans. But the present system of investigation and decision making --determining tolerance levels, dose response curves, threshold levels, and unequivocal cause-effect linkages in order to regulate on a chemical-by-chemical basis--will never solve our problem."[17]

RECOMMENDATIONS:

Before approval industry should be required to test pesticidal compounds presently being marketed and new products (their metabolites, intermediates and by-products) for multigenerational immune, endocrine, reproductive and nervous system effects in at least 3 animal species and their environmental fate in all media.[17]

In order to control the sources of harmful chemicals, Germany has instituted a comprehensive policy to reduce dioxins and toxic chemicals. There is already some evidence of improvement in dioxin body burdens and purity of breast milk.[18] The United States needs such strict regulation.

Greenpeace advocated total ban on chlorine products. PVC's are included because of the wide usage in homes (flooring, pipes, blinds, wallpaper, furniture, toys) and in case of home fires the smoke can be lethal, and if and when these products become waste, they become a source of dioxins especially if incinerated.

Landfilling of waste is safer and less expensive than incineration. If wastes are incinerated the waste should be free of plastics, petroleum products, pesticides, batteries, and tires. Further, incinerator emissions should have unscheduled and frequent monitoring during normal operating conditions.

The use of plastics for packaging manufactured products and the widespread use of plastic gowns and bedding in hospitals should be reduced except as required for health reasons.

We all should work to strengthen laws to protect air and water purity, the important link in dioxin contamination and consumption.

Jim G. Hendrick, M.D.

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Dr. Hendrick is a retired pediatrician. He practiced with the Children's Medical Group in Jackson. He was a member of the American Academy of Pediatrics' (AAP) Committee on Environmental Health (1992-96). He currently serves as a member of Physicians for Social Responsebility (PSR).

Medicine as Big-Business Undermines Health Care System

Dear Editor:

David Broder's column in *The Sun Herald* (Biloxi, MS), October 26, "Rising costs, declining access undermines the health care system," reinforces the sad truth about the health services industry; which is a complicated system of market forces, managed care, privatized health maintenance organizations (HMOs), insurance conglomerates, and piecemeal legislation that will never insure genuine health care for the American people.

His column asserts, "It is time for another effort at comprehensive health care reform. Time to realize that reform of health care by business managers and chief executive officers of insurance companies has not happened; time to find other ways of job creation, a result which politicians brag about; time to understand that health care reform will not come about by training people and calling them "medical specialists;" time to conclude that health care reform based on microeconomic principles will not happen; past time for the medical profession to recreate a valued institution based on doctor-patient relationship once called "The Practice of Medicine."

There are surviving remnants of humanitarian doctors within organized medicine who CARE, who base their work on healing principles like "First, Do No Harm," and who realize that they and their patients are slaves to an oversold, overbought, overvalued, specialized system controlled by big business.

In Mississippi there are practicing physicians within the State Medical Association who do not approve of the association becoming big, business, and who are working to reestablish principles of healing that can overcome economic principles.

Many patients who have run the economic gauntlet through clinics and hospitals no longer doubt that something is terribly wrong. As a valuable system that cares, it is unsustainable.

Perhaps one solution is for compassionate health care students and primary health care physicians to organize and segregate themselves from purveyors of oversold, overbought hi-tech practices, and to refuse to join greedy entities of an enslaving medical services industry.

Sick people need more astute columnists like David Broder to help state and federal legislators overcome their particular kind of enslavement by the special interest, health services industry.

John Alford, M.D.

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Medical Ethics Conference to be Held in March

Baptist Health Systems and First Presbyterian Church, Jackson, will host a Conference on Medical Ethics on March 28, 1998 at First Presbyterian Church. The conference will emphasize end-of-life issues, and will feature nationally-known speakers on the subject including Dr. Christopher Hook and Dr. Chris Sigolla from the Mayo Clinic and Nigel Cameron, Chairman of the International Advisory Board, Center for Bio-Ethics and Dignity in Illinois. The conference is open to the public, For information, call First Presbyterian Church at 973-9115.

Mississippi State Department of Health Announces New Grant To Help Reduce Infant Mortality

A three-year, $142,000 grant award to Mississippi State Department of Health will help Mississippi expand efforts to continue and also intensify its steady overall downward trend in infant mortality.

State Health Officer Dr. Ed Thompson announced the award.

The 1996 Mississippi infant mortality rate of 11 per 1,000 live births, one of the state's third lowest rates in history, is down dramatically from the 1980 rate of 17,1970 rate of 29.1, and 1960 rate of 41.5.

The new Special Projects of Regional and National Significance (SPRANS) grant will enable The Health Department to systematically collect and study information that could reveal why Mississippi youngsters too often die before their first birthday. The U.S. Health Resources and Services Administration funds SPRANS. Dr. Bill Roberts, associate professor of maternal-fetal medicine at the University of Mississippi Medical Center, will assist as primary consultant for the project.

Although Mississippi's infant mortality rate has continued to decrease over time, the state consistently reports at or near the top in the nation.

• Mississippi is a rural state with a high proportion black population, low per capita income, and a high percentage of children living below the poverty level - all factors associated with a high death rate for expected and newborn babies.

• The number of family practice physicians who provide obstetric care has decreased by over 50 percent since 1987, and the number of hospitals that provide obstetric and newborn services has steadily declined.

The SPRANS grant will allow expansion of the Fetal and Infant Mortality Review (FIMR) process that already exists in three Mississippi counties: Lowndes, Monroe, Oktibbeha.

The call for statewide infant death reviews came from the Infant Mortality Task Force through their 1996 report and recommendations. Task Force Member Deborah Griffin, administrator, and Humphreys County Hospital contributed to prepare the grant application.

The Fetal and Infant Mortality Review process involves:

• collecting information from the delivering hospitals and physicians

• interviewing the parents of infants who died

• building a statewide data base, and

• identifying problems and possible solutions.

The Health Department will develop the FIMR information-gathering and analysis process in four more counties: DeSoto, Grenada, Tate and Yalobusha Counties, with plans to go statewide during the next two years.

FIMR planners believe the project can help reduce infant mortality through showing policy makers and health providers changes they and the communities must make to help prevent fetal and infant deaths. Establishing a data base of practice patterns and other distinct factors that have contributed to too-soon deaths and then identifying common threads can help develop new policies and standards for practice.



Left to right ***David Duncan, Dr. Dwalia South, Lt. Governor Ronnie Musgrove.***

ACS Supper Raises $5,735

In her introduction of Lt. Governor Ronnie Musgrove at the American Cancer Society supper held last fall, Dr. Dwalia South related a story about her 10-year-old son, Jack.

Dr. South, who has been president of the local chapter for several years, said she pointed out the lieutenant governor to Jack, saying, "He is the number two man in the state. Do you know his name?"

She said her son replied, "Al Gore." The chuckles she elicited set the tone for the evening's benefit.

With equal humor and a light touch, Musgrove said he grew up in the suburbs of Batesville. Actually, he said, his family lived 10 miles outside of Batesville, population 42. But that statistic rose and fell through the years, he said. Using as an example the time he left for college, Musgrove said the population dropped by one to 41.

A small country store served as the focal point for the community. To call it a store is an overstatement, he said, but as a child he recalled six of the townsmen sitting on the porch "phylosophyin'."

From that porch is where he announced his candidacy to run for State Senate from District 10, he said.

And, the same six older gentlemen, he said, were sitting there when he launched his campaign. Musgrove said he had wanted to be a lawyer since he was eight years old but when he was accepted by Ole Miss to attend law school he was apprehensive.

What made him apprehensive, he said was attending law school with students who came from much larger school systems. It was a bit daunting, he explained. But on his first day, he sat next to another first-year law student, and after a few minutes of conversation, he determined that if school officials had confidence that this other young man could succeed, then Musgrove believed he would succeed as well.

He admitted learning later in life that the other student had similar feelings at the time. Then he revealed that the other student was none other than novelist John Grisham. Speaking of his own aptitude, Musgrove said obviously he did not recognize talent when he saw it.

Shifting to a more serious tone, he said his mother died of cancer at the age of 60. She passed 90 days after

her diagnosis and was hardly recognizable he said.

Through the years he has thought about how debilitating a disease cancer is and how necessary it is to find a cure. This has given him new resolve he said to do what he can.

He thanked those who were attending the dinner for their commitment along with others around the country in raising funds for the American Cancer Society.

In describing his vision for Mississippi, Musgrove said with all the needs in the state, it would be impossible to make all of them a priority. To be successful, he said he has narrowed his focus to accomplishing three goals. Educating children, making good jobs available and communities safe for people are his priorities for Mississippi, he said.

But, he said just like finding a cure for cancer, he cannot do it alone. No one is good at all things, he said, drawing examples from life. But in essence he said, it takes the talents of many people working together to accomplish what needs to be done. "Working together, we can make a real difference," he advised, "working together at solving the state's problems."

Then he opened the floor to questions. American Cancer Society field representative Charles McVey asked several questions, including, "Who will have spending authority over the tobacco settlement funds?"

Musgrove pointed out that the money is not under the state's control yet, so it is too soon to budget that money, he said. But the legislature has the authority to make appropriations, he said.

Parties to the lawsuit also might draft an order setting out parameters for expenditure of those funds.

And, Musgrove said he thinks some of the funds should be put in an escrow account and the interest should be used leaving the principal untouched.

This year some planning time has been lost, he said, and there should be a process in which there is sufficient planning.

"There is no substitution for preparation and hard work," he concluded.

Proceeds from the Musgrove dinner came to $5,735, compared with last year's supper which earned $4,300.

At the first supper held in Tippah County in 1986, $3,000 was raised. In the interim the dinner has garnered up to a high of $7,808 when Pat Nunnally spoke in 1991.

Pharmacist David Duncan, who has worked behind the scenes for the last several years coordinating the annual supper, told those gathered Green Old Field restaurant Tuesday evening that proceeds from the eleven previous supper have raised $65,000 for the American Cancer Society.

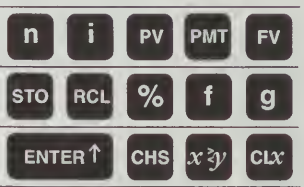
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Pine Grove Presents $4,000 Check to the Caduceus Club

A luncheon was held at Pine Grove Counseling Center of Jackson in honor of the Caduceus Club of Mississippi to present the Club a check in the amount of $4,000.

This was Pine Grove's third annual contribution to support the Caduceus Club which has about 120 members statewide. The funds are used for monitoring and advocacy of health care professionals in recovery.



***Vicki Pevsner**, (center) Administrator of Pine Grove Counseling Center, an extension of Forrest General Hospital, presents a third annual contribution check to **Kay Gatewood**, Executive Director of the Caduceus Club of Mississippi, and **Dr. Ellis M. Moffitt**, Medical Director of the Caduceus Club.*

MSMA Recognized at the Mississippi Society of Association Executives "Associations Advance Mississippi" First Annual Awards Reception

The Gala Awards Reception for "Associations Advance Mississippi", the public awareness and awards campaign created by the Mississippi Society of Association Executives and sponsored in part by the Mississippi Department of Economic and Community Development, Division of Tourism, was held November 6, 1997 at the Governors Mansion in downtown Jackson.

MSMA received second place for the MSMA and MSMA Alliance "Health Choice '97" campaign, an educational program to help Mississippi school children make good health choices and "Just Say No" to drugs, alcohol and violence. Entries were judged by three association executives from neighboring states.



***Lt. Governor Ronnie Musgrove** presents MSMA Director of Communications **Karen Evers** on behalf of the Assoociation's Second Place Award at MSAE's "Associations Advance Mississippi" Awards Reception, November 6, 1997 at the Governor's Mansion in Jackson, MS.*

Utilization Peer Review Program Underway

Contract Signing



Signing a review contract between Blue Cross & Blue Shield of Mississippi and the Foundation are, from left standing, Dr. Tom Fenter and Richard Hale, and seated, Dr. James S. McIlwain Jr. Dr. Fenter is medical director of Blue Cross & Blue Shield, and Mr. Hale serves as the president of Blue Cross & Blue Shield. Dr. McIlwain, president of the Foundation, Mississippi's peer review quality improvement organization, stated, "This gives Blue Cross & Blue Shield access to locally practicing physicians and assurance of true peer review using local standards of care. Mississippi physicians representing all medical specialities belong to the Foundation, which has over 25 years experience in the peer review, quality improvement field." Blue Cross & Blue Shield, a mutual insurance company, is the state's largest health insurance company and is one of 58 independent licensees of the national Blue Cross & Blue Shield Association.



Denise Auttonberry, PhD, RNC, CNAA, CHE

Market Research and Development for Foundation

Denise Auttonberry, PhD, RNC, CNAA, CHE, has joined the Foundation staff to serve as manager of market research and development. Formerly with the Madison County Medical Center as director of clinical affairs, she has been a member of the American Nursing Association since 1985 and is an active member of the Mississippi Hospital Association Organization of Nurse Executives. She has also been appointed to the Regents Advisory Council of the American College of Healthcare Executives. Dr. Auttonberry will utilize her clinical, educational, consultative and managerial expertise in program development for the Foundation.

New Project

The Foundation's newest Health Care Quality Improvement Program (HCQIP) project is community-acquired pneumonia.

The Medicare Quality Indicator System (MQIS), a standardized data collection system developed to assess the quality of care for hospitalized patients with specific clinical conditions, established a national module. The pneumonia module included developing and testing valid and reliable indicators for the quality of care for patients with pneumonia. It also included establishing baseline measurements of quality indicators focusing on the processes of care that may ultimately be linked to positive patient outcomes, such as decreased morbidity, mortality, and resource consumption.

Data from the MQIS pneumonia project demonstrated opportunities for improvement in Mississippi in the three quality indicators to be addressed in the FMC project. These quality indicators are administration of antibiotic within four hours following arrival at hospital; assessment of oxygenation within the first 24 hours; and obtainment of blood cultures within the first 24 hours. Medicare Part A claims data for Jan. 1, 1996, through Dec. 31, 1996, reveal that DRG 089 (Simple Pneumonia and Pleurisy Age greater than 17 with comorbility complication) represents 3.8 percent of the total Medicare cases for the year and 5.05 percent of the total deaths for the year.

Data abstraction for the project is tentatively set to begin in early spring. Dr. Candace Keller is clinical coordinator.

For further information, contact the Foundation office at 601-354-0304.

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MSMA
130th Annual Session

"Medical Practice in Mississippi: Current Issues in Preventive Health, Ethics and Government."

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Don Q. Mitchell, M.D., of Jackson, was elected vice president of the American College of Allergy, Asthma & Immunology (ACAAI) during the College's annual meeting in San Diego. Dr. Mitchell is clinical associate professor of medicine at the University of Mississippi School of Medicine and a private practitioner at the Mississippi Asthma & Allergy Clinic. A fellow since 1979, Dr. Mitchell received the ACAAI Distinguished Fellow Award in 1996. He served as treasurer 1993-97, and on the Board of Regents and Executive Committee since 1993. He is a member of the Finance Committee, Annual Program Committee and co-chairs the Committee of 200. His past College appointments include chair of the Finance Committee, chair of the Publications Committee, chair of the Credentials Committee and member of the Ethics Committee. Dr. Mitchell is on the Board of Governors of the American Association of Certified Allergists. He is a Fellow of the American College of Physicians.

Dwalia South, M.D., of Ripley, was elected Vice-President of the Mississippi Academy of Family Physicians for 1997-1998 at their 49th Annual Scientific Assembly in Perdido Beach, Alabama. She has been a member since 1981. The Mississippi Academy of Family Physicians has 787 physician members. It is the largest medical specialty society in our state. Dr. South had an opportunity to earn up to 23 hours of CME by attending a variety of educational forums.

Ralph Vance, M.D., of Jackon, has been elected chairman of the new Mid-South Division board of directors and delegate to the American Cancer Society's National Assembly. The board members of the Mid-South Division, a six-state region, selected Vance and 13 other volunteers to join ACS representatives from around the country for the Annual National Assembly Meeting. Dr. Vance is a professor of medicine in the oncology division at the Universityof Mississippi Medical Center. A volunteer for 20 years, he serves the ACS in numerous roles, including membership on the national board of directors and on various committees. Dr. Vance is a recipient of the St. George Medal, the highest honor given to a volunteer for dedication in fighting cancer.

Ann Rea, M.D., an anesthesiologist, has been named chief of staff for Southwest Mississippi Regional Medical Center in McComb for 1997-98 by the medical staff executive committee. Gastroenterologist **Simon Cofrancesco, M.D.** has been named secretary-treasurer; Pathologist **Duane Broussard, M.D.,** chief of staff-elect; Obstetrician-Gynecologist **David Hubbs, M.D.,** member at large; Family Practitioner **Henry Lewis, M.D.,** medical director; Pediatrician **Michael Artigues, M.D.,** chief of medicine. Ear, Nose and Throat Specialist **Lawrence Stewart, M.D.** is past chief of staff.

W. Briggs Hopson, M.D., of Vicksburg has been reappointed a clinical associate professor of surgery and a visiting teaching physician by the board of trustees of the University Medical Center (UMC). Dr. Hopson is a general and peripheral vascular surgeon with The Street Clinic, chief of staff of ParkView Regional Medical Center, medical director of the clinics and member of the board of directors of River Region Medical Corporation. A physician in Vicksburg for 30 years, Hopson is a member of the Governor's Commission on Health.

Billy Mack Pickering, M.D., has relocated to his new clinic, HubSouth Medical Center of Seminary. Dr. Pickering was temporarily in practice with **Dr. J. David Bullock** at the HubSouth Medical Center of Sumrall. A native of Collins, Dr. Pickering is a graduate of Mississippi College. He received his medical degree from the University of Mississippi Medical Center in Jackson and completed a family practice residency at the DCH Regional Medical Center in Tusca-loosa, Alabama. For the past nine years Dr. Pickering practiced as an Emergency Physician in Forrest General Hospital's Emergency Department. Dr. Pickering is board certified in family practice.

Dwight S. Keady, M.D. announced his retirement from active medical practice.

J. Spencer Mooney, M.D. and the Brookhaven Ear, Nose & Throat Clinic are pleased to announce the establishment of the Mississippi Sinus Center in Brookhaven.

Gene Barrett, M.D., a surgeon with the Mississippi Sports Medicine and Orthopaedic Center in Jackson, has been named to the Millsaps College Board of Trustees. He attended Millsaps and graduated

from the University of Mississippi School of Medicine in 1974. He completed fellowships in knee surgery at the Hughston, Or- thopaedic Clinic in Columbus, Georgia, and an A-O International fellowship in Basel, Switzerland. Among his memberships: American Academy of Orthopaedic Surgeons, International Society of the Knee, Arthroscopy Association of North America and the American College of Sports Medicine.

James Woodard, M.D., an internist, is the new chief of the medical staff at Baptist Memorial Hospital-Golden Triangle. Dr. Woodard assumed the position October 1, from Dr. Walter Cosby, otolaryngologist. A native of Alabama, he received his undergraduate and medical degrees from the University of Alabama. He completed both his internship and resi-dency in internal medicine at Car-raway Methodist Medical Center in Birmingham, Alabama. In 1988, he returned to Columbus to practice medicine and joined the staff at what was then Golden Triangle Regional Medical Center. Dr. Woodard is medical director and partner at Internal Medicine Associates in Columbus. He is board certified in internal medicine and is a member of the American Medical Association, the American College of Physicians and serves as an American Heart Association Affiliate Faculty Member for Advanced Cardiac Life support (ACLS).

Roderick T. Cutrer, M.D., a family practice physician at Hattiesburg Clinic, completed the recertification examination of the American Board of Family Practice and is recertified as a diplomate until December 31, 2004. He has been granted graduate faculty status as "Doctoral Committee Associate" at the University of Southern Mississippi. This ranking enables him to serve on masters and doctoral committees in various programs within the College of Health and Human Sciences. He will also assist the college as an adjunct professor of laboratory science and a physiology consultant.

A. Lamar Glaze, M.D., obstetrician-gynecologist at Hattiesburg Clinic, has successfully completed the requirements for recertification as a diplomat by the American Board of Obstetrics & Gynnecology. Dr. Glaze received his medical degree from the University of Mississippi School of Medicine in Jackson. He completed his internship and residency at Tulane University Ob-Gyn Residency Program at Charity Hospital in New Orleans. He has been with the Hattiesburg Clinic for eight years.

Dr. Scott P. Guidry, M.D. was recently inducted as a fellow in the American College of Surgeons at their annual meeting held recently in Chicago. He is a general and vascular surgeon at the Hattiesburg Clinic, P.A.

Gerry Ann Houston, M.D., of Jackson Oncology Associates, will serve as medical director of the new Baptist Health Center's Comprehensive Breast Center, created to help provide new ways to diagnose, treat and educate women about breast cancer and other diseases of the breast. The Center, which will work with the Healthcaring Center for Women, was created under the leadership of a multi-specialty task force of physicians, along with input from the community. The Center, being built in Jackson, will offer the latest technology to diagnose and treat breast cancer, including mammography, a stereotactic biopsy unit, ultrasound, and computerized tracking of patient cases. Bi-monthly Patient Care Conferences will allow multi-specialty physicians to coordinate patient care. Support and education services to be provided include physician-approved educational materials, support groups, therapeutic exercise; access to a breast health specialist, mental health and fitness/ nutrition counseling, a library and an Appearance Center where women can get wigs, breast prostheses and personal care items.

Guy Farmer, Jr., M.D. gave facts on "Breast Cancer Awareness," for the Mississippi Homemaker Volunteers for the North Central Area Fall meeting recently in Bruce, Mississippi.

Luis R. Pernia, M.D., a plastic surgeon at Southeastern Plastic Surgery Associates in Tuscaloosa, Alabama, has received a grant of Letters Patent from the U. S. Patent Office for inventing a creative use for human hair. Dr. Pernia uses biologically cleansed human hair as a replacement for soft tissue in restorative surgery. Restorative surgery can include dermal fat grafts and breast implants. He envisions hair as replacement filler or structure substitute for patients that suffer from a loss of tissue mass or were born with deficient tissue mass. Because human hair has antigens and antibodies consistent with the rest of the body, it is less susceptible to rejection and passes the body's defensive mechanisms. Hair properly harvested and treated is seen as a viable biological replacement material which does not suffer rejection when placed inside the body.

Nelson Apostol, M.D. presented an informative talk, "Diabetes: What to Know Head to Toe" for Trace Regional Hospital's Lunchtime Learning program, Houston, Mississippi.

Charles D. Scruggs, M.D. is now associated with the Men's Health Center. Dr. Scruggs is board certified in urology and specializes in Male Sexual Dysfunction.

William E. Lotterhos, M.D., chief medical officer at the Jackson Military Entrance Processing Station, for more than ten years, retired closing out a 57-year medical career. Dr. Lotterhos was responsible for all physical examinations of enlisted applicants for service in the United States armed forces from 57 Mississippi counties. A native Mississippian, Dr. Lotterhos attended Millsaps College and Mississippi State before receiving his B.S. degree from the University of Mississippi in 1938. He received his M.D. degree from the University of Tennessee in 1940 and took his postgraduate studies in anesthesiology at the University of Tennessee and a course in general practice at Emory University after World War II. After medical school, he accepted internships at Mississippi Baptist Hospital, in Jackson. He undertook Ob-Gyn assistant residency at Methodist Hospital, Memphis, Tennessee. From 1942 to 1945, he served in the U.S. Army Medical Corps. During two years in the Italian campaign, he received the Bronze Star, Purple Heart, Combat Medics Badge, Legion of Merit and Italian Military Cross of Valor. Lotterhos was chief of staff at Mississippi Baptist Hospital in 1956, and was on the consulting staff at Mississippi Baptist, St. Dominic's Hinds General and Doctors Hospital of Jackson, Inc. Lotterhos was the assistant clinical instructor at the University of Mississippi Department of Preventive Medicine for 11 years. His many contributions to literature include, "Recent Trends In Geriatrics" and "To Teach Them This Art" in a 1966 issue of ***JAMA***. W.E. "Mike" Caldwell, M.D., of Ridgeland, succeeds Dr. Lotterhos as Chief Medical Officer. Dr. Caldwell previously served as Medical Director at Blue Cross & Blue Shield of Mississippi.

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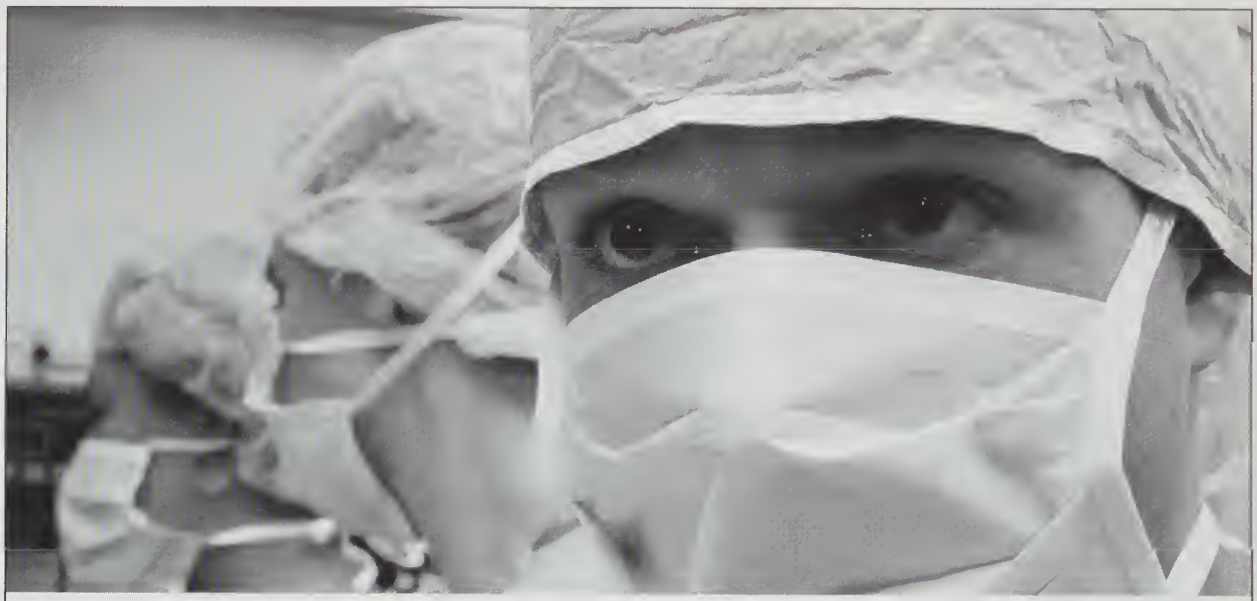
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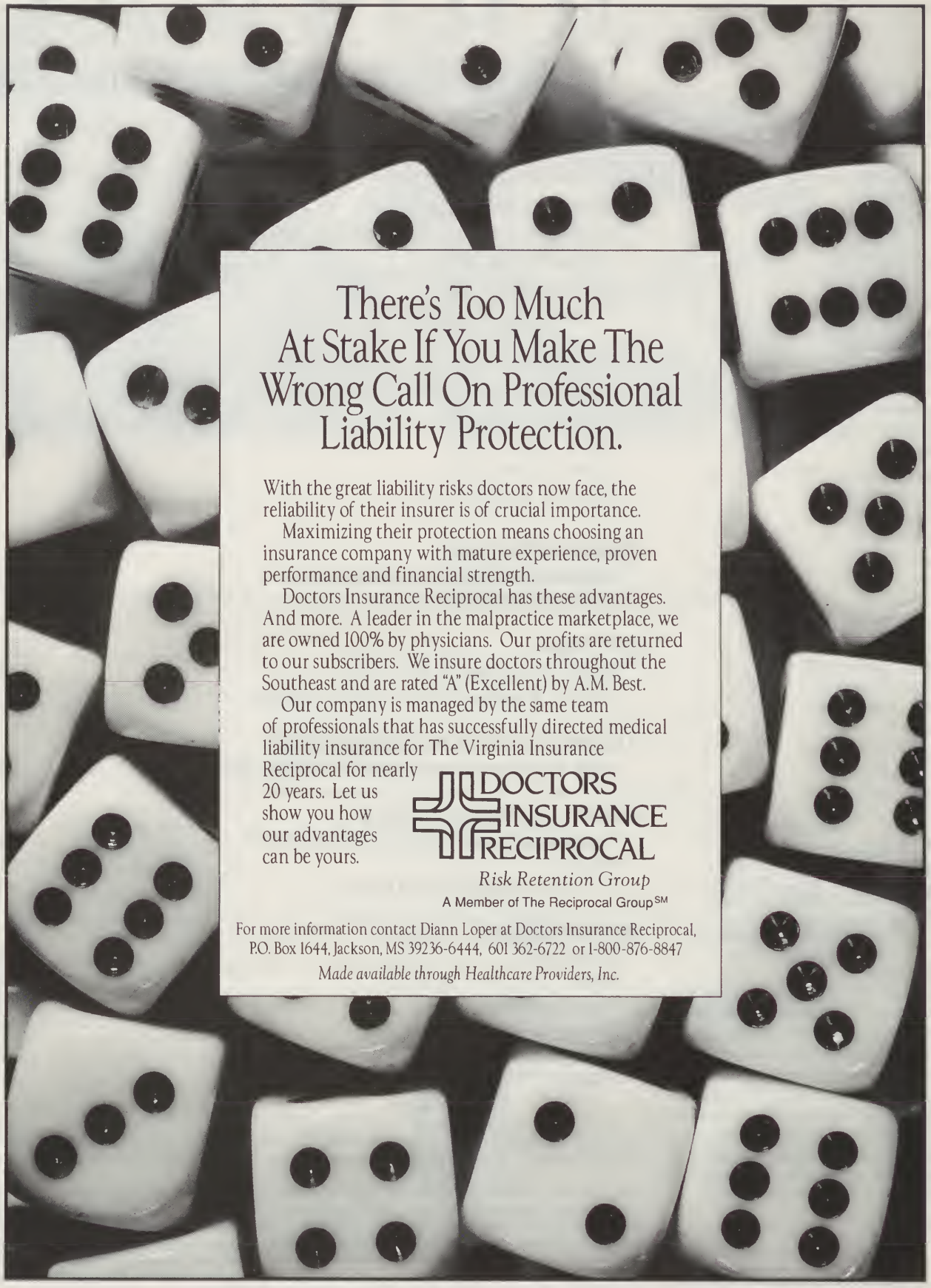
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Catheter-directed Thrombolysis for Deep Venous Thrombosis

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Key words: ***urokinase, thrombolysis, catheter-directed***

Introduction

Deep venous thrombosis is a common clinical problem. An estimated 2 to 3 million new cases occur annually in the United States.[1] The sequelae include pulmonary embolism and postthrombotic syndrome. While much clinical attention has focused on embolism because of potential loss of life from this complication, the incidence is actually quite low (12% to 20%; mortality 0.5% to 3%) compared to postthrombotic syndrome, which develops in 50% to 70% of patients after a bout of deep venous thrombosis.[2] Roughly half of these patients have the severe form of the syndrome. The reported incidence is probably an underestimate because of the slow evolution and indolent presentation of the syndrome. Several years and even decades may elapse before patients become symptomatic, typically following a recurrent bout of thrombosis that results in decompensation of an already damaged venous system. The direct and indirect costs of treating the syndrome are staggering.[3] Because many in the working age population are affected, man hours and wages lost in the workplace contribute significantly to the social costs of this problem.

It is now recognized that a combination of outflow obstruction and valve reflux is the pathophysiological basis of the postthrombotic syndrome.[4] These pathologic alterations are directly related to the onset and evolution of the thrombus load. Rapid elimination of the thrombus load after onset would logically be expected to eliminate or at least ameliorate the evolution of postthrombotic syndrome. It is well established that the conventional heparin-warfarin anticoagulation regime has little or no thrombolytic role, hence the thrombus load remains largely unchanged. In about 20% of patients, the thrombus load may actually increase during the early period of anticoagulant induction.[5] For this reason the incidence of postthrombotic syndrome has remained unaffected by the introduction of anticoagulant therapy for deep venous thrombosis. The major benefit has been a reduction in the incidence of pulmonary embolism.

There have been a number of attempts, particularly in Europe,[6] to employ therapeutic approaches other than heparin-warfarin removal of the thrombus load after the onset of deep venous thrombosis. These have included systemically administered thrombolytic agents and surgical thrombectomy. The latter procedure pioneered by Mahorner[7] in the United States in the 1940s, quickly lost favor due to a high incidence of recurrent thrombosis.[8] The procedure was resurrected in Europe and has remained popular with the addition of a temporary adjuvant A-V fistula to the thrombectomy procedure, which eliminated the problem of recurrent thrombosis.[6] A meta analysis of the thrombolytic and surgical approaches to the elimination of the thrombus load shows a clear advantage over conventional anticoagulant therapy in terms of venous channel patency and reduction in the onset of clinical symptoms of postthrombotic syndrome.[6] The recent advent of catheter-directed technologies for the administration of thrombolytic agents in the arterial

system, particularly the spectacular results achieved in the coronary and peripheral vascular thrombosis, has rekindled interest in their application in deep venous thrombosis. The previously noted superior results in the meta analysis lend some credibility to this approach. A national registry that was established only a few months ago for collecting uniform data on this thrombolytic technique already has nearly 200 entries. In this report, we describe our experience with catheter-directed thrombolysis in 24 cases of deep venous thrombosis.

Materials and Methods

Since the initiation of the program in July 1995, twenty-four patients have been treated with urokinase using the catheter-directed technique. Patients ranged in age from 17 to 70 (16 were male and 8 were female). Eighteen patients (80%) were treated within 3 weeks of the onset of deep venous thrombosis based on history while the remaining six patients were treated 3 to 24 weeks after the onset.

Deep venous thrombosis was confirmed by ascending venography prior to the initiation of treatment. The proximal extent of the thrombus was as follows: IVC 5, iliac 7, femoral 10, and popliteal 2.

Technique of Catheter-Directed Thrombolysis

The original internal jugular or contralateral femoral approaches have been abandoned in favor of ipsilateral venipuncture for catheter placement. Coaxial catheters for infusion of urokinase are preferentially used to traverse the entire length of the thrombus. This generally involves a "criss-cross" technique of employing two separate coaxial catheters for proximal and distal thrombus coverage when the venipuncture site is either femoral or popliteal vein midway in the extent of the thrombus. A single catheter traversing the entire thrombus can usually be employed if the portal of catheter entry is the posterior tibial vein near the ankle or the soleal sinusoid. Between 150,000 to 200,000 units of Urokinase per hour, divided between the catheters and the sheath, are administered for 24 to 72 hours to achieve complete or maximum possible clot dissolution. Intravenous heparin is simultaneously administered, preferably through the sheath or other venous access. Progression of thrombolysis is monitored by contrast venography at 24-hour intervals, at which time catheter positions may be readjusted and residual stenotic lesions may be balloon dilated or stented. Serum fibrinogen levels, fibrin split products and other coagulation parameters are routinely monitored every 12 hrs for the duration of thrombolytic therapy. Prior to the institution of thrombolysis all patients should be screened for hypercoagulability and the presence of occult malignancy. Warfarin anticoagulation is instituted with cessation of urokinase, but heparin therapy is continued until targeted INR (International Normalization Ratio) levels are achieved. Patients have been followed up at 3-month intervals after thrombolytic therapy.

Catheter-directed thrombolysis is contraindicated during pregnancy, after recent surgery (<12 days), recent stroke, gastrointestinal hemorrhage, cerebral metastasis or thrombus in cardiac chambers.

Results

No mortality or major complications followed the procedure; one patient died twelve months later from coexisting malignancy. Two of 24 patients experienced local discomfort and hematoma at the venipuncture site; surgical intervention to stop the local bleeding was not necessary. Transfusion was required in two patients to maintain an adequate hematocrit. Complete thrombus clearance was achieved in 17 patients and partial clot clearance in four, while thrombolysis in the remaining three was considered unsuccessful. Balloon dilatation of a residual stenotic lesion was required in 12 patients, of whom six (25%) also required a stenting procedure (Fig. 1). At 3-months follow-up 79% of treated patients remain asymptomatic, 17% are improved over pretreatment symptomatology with residual symptoms, and 4% are considered to have received no therapeutic benefit from thrombolysis. Based on the arm-foot venous pressure differential technique,[9] 81% of treated patients remain free of significant venous outflow obstruction. This hemodynamic technique is considered the most sensitive of currently available techniques to measure venous obstruction.[3] Although duplex indicates that in 58% of

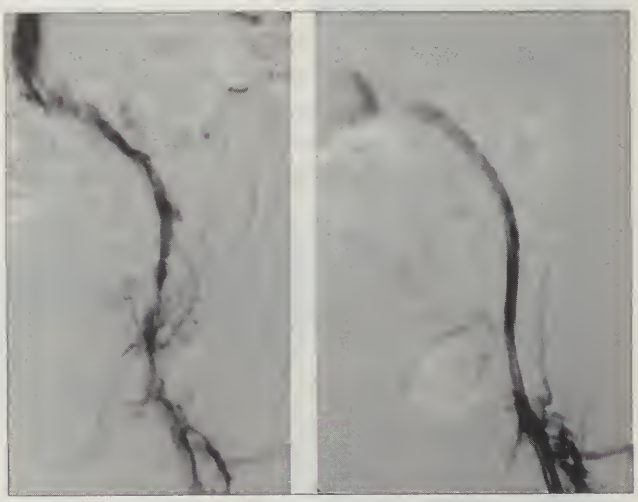


Figure 1. *Residual stenosis after thrombolysis of iliac vein thrombus (left) treated by a long stent (right).*

treated patients the venous valves in the segment occupied by the thrombus prior to dissolution are fully functional and competent, 77% of patients evince some evidence of reflux by airplethysmography or ambulatory venous pressure measurement.

Illustrative Cases

Case 1: A 17-year-old female was referred for sudden onset of bilateral leg swelling. She had been a passenger in a motor vehicle accident 3 weeks previously, but sustained no obvious injuries. Mild antithrombin III deficiency was present. Venography demonstrated extensive deep venous thrombosis extending proximally into the vena cava up to the renal veins (Fig. 2a&b). Catheter-directed thrombolysis was successful in complete resolution (Fig. 2c). One year after the intervention the patient is completely asymptomatic with no evidence of valve damage.

Comment: *Patients with such an extensive deep venous thrombosis are invariably symptomatic with traditional anticoagulation therapy. Restoration to an asymptomatic status is therefore unique to catheter-directed thrombolytic therapy.*



Figure 2a.



Figure 2b.



Figure 2c.

Figure 2. *Iliac vein thrombus (a) extending to the inferior vena cava (b) with complete resolution after urokinase thrombolysis (c).*

Case 2: A 63-year-old otherwise healthy male sustained deep venous thrombosis of the left lower extremity during Thanksgiving holidays, which was documented by Duplex scan. He was treated with conventional anticoagulation regimen with persistent moderate swelling and pain in the affected leg. He extended the thrombus on anticoagulation in February 1997, nearly 4 months after the initial event. Owing to excruciating pain associated with the new clot extension, he was treated with catheter-directed thrombolysis in the hope of restoring to the previously symptomatic level of tolerable pain. Surprisingly complete thrombolysis was obtained including the 4-month-old clot. The patient is totally asymptomatic 2 months after successful thrombolysis.

Comment: *Thrombolysis of a clot older than 3 weeks is rare. Clot resolution, however, can occur to a variable extent in a thrombus up to 6 months after its formation because of individual variation in the time course of thrombus organization. In rare instances, as in the case above, the thrombus fails to show any evidence of organization even after several months of initiation apparently because of a process of ongoing dynamic lysis and thrombosis. The precise mechanism of this phenomenon is unknown.*

Discussion

Traditional anticoagulation remains the gold standard of therapy for deep venous thrombosis. It has been highly effective in reducing the incidence of pulmonary embolism and the dreaded sudden death syndrome from this cause. The incidence of postthrombotic syndrome, however, has remained unaffected with this mode of therapy. This complication, while less dramatic than embolism, is more insidious and extracts a high monetary and social cost on the affected population. Many of these patients are in their productive years in terms of physical work and activity. A more aggressive approach toward thrombolysis rather than stabilization of existing thrombus load in this group of patients would seem to be justified. Short-term data and experience are promising but long-term follow-up is required to establish a benefit in reducing postthrombotic syndrome after catheter-directed thrombolysis.

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Renal Cell Carcinoma In Native Kidneys Of Patients With End Stage Renal Disease

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Key words: *Renal cell carcinoma, dialysis, end stage renal disease*

Abstract

Objective

To determine prevalence of renal cell carcinoma in a cohort of patients with end stage renal disease who underwent nephrectomies for suspicious cysts or masses.

Methods

A retrospective review of patients with end stage renal disease who were receiving hemodialysis and underwent nephrectomies were identified and those charts were reviewed.

Results

Twenty patients, from a total of 400 patients with end stage renal disease, had nephrectomies preformed for various reasons. Of these twenty patients, four were found to have renal cell carcinoma with an occurrence rate of 5% in these patients. At followup from 1-9 years, all patients are alive without evidence of disease.

Conclusions

Patients with end stage renal disease have an increased prevalence of renal cell carcinoma. While the patients in this series have a 100% survival at 1-9 year follow-up, the overall survival rate in published reports is 35%. The need is to identify patients at high risk for the development of this disease and perform annual screening.

Introduction

Previous reports have described an increased incidence of renal cell carcinoma in patients on hemodialysis. However, Chandhoke et al disputed this finding and stated that there was no increase in the incidence of renal cell carcinoma among this patient population.[1] We reviewed a subset of dialysis patients to determine the occurrence rate, presentation, and survival among these patients diagnosed with renal cell carcinoma.

Materials and Methods

Patients with end stage renal disease on hemodialysis who underwent either a bilateral or unilateral nephrectomy from 1984-1994 were identified. Twenty patients of a total population of 400 dialysis patients had a nephrectomy performed during this time period. All nephrectomies were performed prior to transplantation and while the patients were on dialysis. All

twenty patients had an abnormal radiographic finding on either ultrasonography or computerized tomography (CT) during evaluation for transplantation or urologic symptoms. All patients prior to initiation of dialysis had an imaging study of the kidneys performed. However, there was no routine radiographic follow-up of the patients unless there was a development of urologic symptoms (eg. hematuria, flank pain).

Analysis of patient characteristics, radiographic findings, length of time on dialysis, and pathologic features of the nephrectomized kidneys was undertaken. Only patients who underwent nephrectomy of native kidneys were considered. Patients with a family history for renal cell carcinoma were excluded.

Results

From a population of 400 dialysis patients, 20 patients with end stage renal disease (ESRD) who underwent unilateral or bilateral nephrectomy from 1984 to 1994 were identified. Of these 20 patients, four patients were identified as having histologically confirmed renal cell carcinoma. The remaining 16 patients demonstrated no evidence of renal cell carcinoma on pathologic examination.

Study Population

The study population consisted of 20 patients with ESRD who underwent unilateral or bilateral nephrectomy. The mean age of the patients was 42.3 years (range 34-60 years) and the male-to-female ratio was 2:3. All patients were on hemodialysis prior to surgery and the average duration of dialysis prior to tumor diagnosis was 4.2 years.

TABLE 1

Presenting Symptoms

Symptoms	(%) No. of Patients
Hematuria	7 (35)
Flank Pain	6 (30)
Radiologic evaluation of patients for end stage renal disease	3 (15)
Incidental Radiologic Finding	3 (15)
Recurrent Pyelonephritis	2 (10)

Presenting Symptoms - Table 1

Hematuria and flank pain were the most common presenting symptoms with 35% and 30% of the patients experiencing these respectively. Six of the patients (30%) were asymptomatic, but showed suspicious cysts or mass lesions on radiographic evaluation. Three patients were being evaluated for ESRD, while three patients had coincidental radiographic findings.

Radiographic Evaluation

All patients underwent renal ultrasound or computerized tomography of the abdomen and pelvis prior to surgery. Eight patients (40%) were identified as having radiographic evidence of a solid renal mass. The size varied from 1.5 to 6 cm in diameter with a mean size of 3.6 cm.

Surgery

In the study population of 20 patients, a total of 32 nephrectomies were performed. Twelve patients underwent bilateral nephrectomy and eight patients had unilateral nephrectomies.

Pathologic Results

Eight patients were identified radiographically as having solid renal mass. The other 12 patients were noted to have suspicious cystic areas in the kidneys. Four patients were proven to have renal cell carcinoma on histological examination following nephrectomy. Three of the 4 patients had concurrent acquired cystic renal disease. Two patients were found to have clear cell type, and two patients had papillary RCC. The stage of all tumors was T_1. The other four patients with solid renal masses on radiographic findings had benign renal adenomas. The remaining 12 patients with cystic areas noted by CT or ultrasound were found to have benign cystic lesions.

Patients With Renal Cell Carcinoma

There was one female patient and three male patients with renal cell carcinoma. The mean age was 49 years old. The average length of time of dialysis prior to surgery was 3 years. There was no statistically significant difference of age at diagnosis or length of time of dialysis between patients with renal cell carcinoma or the remaining patients with benign disease.

Survival

The length of followup of these patients range from 1 to 9 years and all patients are currently disease free. Three patients remain on hemodialysis with the other

patient on peritoneal dialysis.

DISCUSSION

There are approximately 145,000 patients on dialysis in the United States today. As there are only 20,000 kidney transplantations performed each year, 125,000 patients remain on dialysis. This represents a significant population at risk for the development of additional medical diseases.

Spees et al reported that the average age of ESRD patients who develop renal carcinoma is significantly younger (mean age 34.8) [than for the general population] mean age 55 years.[2] It has been noted that there has been an increase in incidence of renal tumors in native kidneys of these patients post transplantation with use of cyclosporin immunotherapy.[3]

In the presentation of symptoms in our population, only one patient had hematuria with the other patients (3) being discovered on routine radiographic evaluation. This is similar to the typical symptomatic presentation of sporadic renal cell carcinoma (RCC) in the general population.[1]

This study reviews the results of our population of ESRD patients in relationship to the development of renal carcinoma. It has been documented that the incidence of RCC in ESRD patients is approximately 1% versus 0.005% for sporadic renal cell carcinoma in the general population.[4] This increased incidence rate in ESRD patients has been challenged however by Chandhoke et al who stated that in their review of dialysis patients the incident rate for renal cell carcinoma was approximately the same rate in the general population.[1] As noted above, in regards to the early age of diagnosis, it is felt that the increased incidence and early age was a result of dialysis. Hughson et al examined kidneys from patients on dialysis and found increased numbers and varieties of epithelial and proliferation in the tubules.[5] It is unknown at this time what mitogenic agents are generated by dialysis which would account for this histologic process to occur. Hughson et al proposed that polyamines which accumulate in the tissues of patients on dialysis may be stimulating to the tubule epithelial cells.[5] Another factor which may contribute to the development of this disease is a depressed immune system in these patients. This has been documented by a low number of lymphocytes with decreased survival time and depressed T-cell activities by Takahashi et al.[6]

In regards to the important and controversial association of acquired renal cystic disease (ARCD) and the development of renal carcinoma in native kidneys, the lack of routine radiographic evaluation of the patient in this report did not allow for necessary data to be collected. The patients in this study underwent an initial pre-dialysis radiographic evaluation of the native kidneys and did not have routine x-ray follow-up. Therefore, patients with ARCD were not identified and no opportunity was available to follow such patients. Acquired renal cystic disease described by Dunnill in 1977 has been both implicated and dismissed as having a role in the development of renal tumors.[8] As the length of time on dialysis increases, the incidence of ARCD does concurrently. Whether this is a result of dialysis associated changes in the kidney as proposed by Grantham et al or a coincidental finding which Chandhoke believes is the case is unclear at the present time.[9]

Levine et al has recommended the identification of a high risk subset of dialysis patients who would benefit from such screening.[7] The current factors which places a patient at an increased risk of the development of renal tumors include length of dialysis and male sex.

In regards to which imaging modality would be cost effective, the choice is either ultrasonography or computer tomography (CT). CT has been found to be preferred in imaging end stage kidney as it can better identify several tumors than ultrasound.[7] However, the annual cost associated with such screening would be prohibitively expensive.

Current treatment recommendations for the finding of a solid mass in a native kidney is radical nephrectomy. The five year survival of patients with end stage renal disease and renal carcinoma is in a range of approximately 35% which is similar to the 42% survival for renal cell carcinoma in the general population. Some investigators have raised the possibility of the relationship between acquired renal cystic disease and its possible causative role in the development of renal cell carcinoma.[4,5] Chandhoke et al in his review of ARCD felt that this process which is present in approximately 8% of dialysis patients at the beginning of dialysis and increases over time to a prevalence rate of 90% of patients over a 5-10 year period on dialysis may represent a finding of coincidence with the occurrence of renal carcinoma.[1]

In light of the increased incidence of renal carcinoma in ESRD patients the question arises regarding the benefit of annual screening of this population. The five year survival rate for renal carcinoma in end stage renal disease patients and the general population is approximately the same.[5] This would indicate that these tumors retain their biological aggressiveness in both patient populations. As stated above, ESRD patients

have a depressed immune system secondary to renal failure in dialysis which could account for the low five year survival rate. Shein and associates have reported that the most common cancer in the dialysis population involved the genitourinary tract (49.5%) and after transplantation this organ system remains the number one site of malignancy (30.2%).[7]

From the above data, annual screening of ESRD patients on dialysis with renal ultrasound would be recommended. However, this would represent a large expense to the health care system due in part to the number of patients currently on dialysis. Further delineation of patients at high risk for the development of renal carcinoma as discussed above could substantially lower the number of patients that would need to be screened and therefore lower the cost factor.[7] Unfortunately due to the small number of patients involved in our review, we were unable to identify any factors that would help to determine patients at high risk for the development of renal carcinoma. Identification of a high risk dialysis patient and annual screening of that population could impact on the increased incidence of renal tumors and hopefully in their increased survival.

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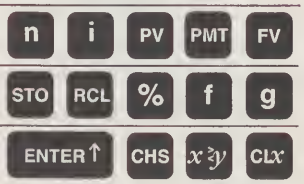
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H. Vann Craig, M.D.

The President's Page

Depression- It's Real and Really Missed

Depression is common in the general population. Of those seeking help, seventy percent present to and can be treated by primary care physicians. They frequently complain of pain, fatigue, or sleep disturbances. It is present as a co-morbid condition with most major illnesses but not given consideration in trauma, infection, stroke, cancer, heart disease, or other debilitating diseases.

Some physicians feel that depression is not a "real" illness and shows a lack of determination, will power, or laziness of the patient. A number of new drugs are available with fewer side effects than tricyclics and monamine oxidase inhibitors. Treatment is frequently with too low dosage and of too short a duration to be effective.

The cost of depression has been estimated at $43 billion each year. Only 30% of this from direct care. The remainder is from premature death and decreased productivity. The economic cost to employers is estimated at $6,000 per depressed patient per year.

The Council on Scientific Affairs has written an excellent report on this subject (CSA report 7-1-97) and I recommend highly to you for study. It can be obtained on the AMA web site under member matters. The password to enter this area is your AMA member number. For those of you who do not surf the web, it can be obtained in hard copy from MSMA.

Vann

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The New York Times: In an editorial, the *Times* criticized policy makers who "*...pretend that physician reimbursements can be cut without affecting health care – as if both doctors and hospitals can be slammed without hurting anyone except the providers of care.*"

Physician Payment Review Commission: In its annual report to Congress, PPRC said the current Medicare reimbursement formula for physicians "*...will set increasingly unrealistic target rates of expenditure growth....*"

Physician cuts alone will not do the job. And the cuts that are currently proposed would actually hurt physicians by rolling back reimbursements so far that they don't even match inflation growth.

That's not fair. It's not fair to physicians, and it's not fair to patients, who ultimately pay the price under such drastic cuts.

What we need is real reform. Real reforms will offset the need for deep, unfair cuts to physicians. The American Medical Association has a plan for reform that offers fiscal stability, expanded choices for patients, a new system of funding graduate medical education, and, above all, fairness.

To learn more about our plan, call 1-888-AMA-1997.



TODAY'S AMA
Giving Power To Your Voice

Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
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MARCH 1998

Nationalizing Health Insurance

Twice now Dr. John Bower has stepped to the microphone at the MSMA Annual Session to propose a resolution for MSMA support for a national health plan - a single payor entity that would insure everyone in the country. He has met with resounding nos, but don't look now, it may be happening anyway in front of our very eyes. In January, President Clinton proposed to extend Medicare coverage to individuals of age 62 to 64 for a fixed rate premium. In addition, workers as young as 55 who found themselves uninsured due to layoff or displacement would become eligible. Each person would pay a premium of $300 - $400 per month.

It's an election year idea that shows Clinton has learned something from the carnage of his national health plan of five years ago. That monstrosity collapsed from its own complicated weight. The new plan is easily understood, involving only an extension of a program currently in place. And, it might well prove as popular with the public as the parent program. Who ever got anywhere politically by opposing an extension of a public health plan to the uninsured? For the Republicans to reject the idea would be politically catastrophic unless they produce a viable alternative.

President Clinton's effort won't stop with this proposal. Expect fairly quick approval for subsidies to help those who cannot afford the premiums. Later will come extensions to those even younger.

What we are witnessing is the slow death of managed care as we know it. The people President Clinton is seeking to insure are those the private insurance industry cannot or will not handle. These patients are money losers, adding to the medical loss ratio, in managed care parlance. The public is becoming increasingly aware of the abuses that are part of the nature of profit-driven managed care. People see doctors on TV throwing tea and HMO annual reports into Boston Harbor. No one objects when the Justice Department brings down Columbia/HCA like the burning Hindenburg.

As managed care organizations become more restrictive of care so that they might improve profitability, or become financially unviable because of tightening regulations, Medicare might become an increasingly popular alternative.

And we, like the Republicans, may be forced to choose what to support.

-Leslie E. England
Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

The Beloved Physician

(Text of the St. Luke's Day "Sermon" given at Trinity Episcopal Church in Hattiesburg, Mississippi by Dr. Ben Carmichael - October 1997. This essay gives us a most appropriate perspective as we approach Doctors' Day 1998.)
-Dwalia S. South, M.D., Associate Editor

On the occasion of the observance of Saint Luke's Day, it has been the tradition in the Episcopal Church that Doctors are recognized and the medical profession as a whole be honored. This is especially befitting, for as you remember our Patron Saint Luke was a Physician by trade.

To honor Saint Luke, allow me a moment to share with you what little I have been able to learn about him and how he relates to us today. He was indeed a Physician, a trusted and loyal friend and coworker of the Apostle Paul. We know from Paul's writings that Luke was a physician "beloved" by Paul. He was with Paul during the Apostle's imprisonment for two years in Caesarea. Luke was a Gentile by birth. This was a unique distinction in that he was the only New Testament writer who was not a Jew. Luke did not achieve great notoriety in the early Christian church and had he not written the Gospel which bears his name, the name Luke would likely not be remembered today. He is mentioned only three times in the New Testament.

Luke's exact birthplace is not known with certainty, some say Antioch, others Philippi or Macedonia. His medical training was very likely in Tarsus, which along with Alexandria and Athens were famous centers of learning in that day.

Some have noted that Luke's vocabulary was saturated with medical terminology; however, this is refuted by others who contend that his writing contained no language beyond the competence and comprehension of the average well-educated Greek of the period.

The Book of Luke, the third New Testament Gospel, was written after the Ascension of Christ as Luke traveled with Paul as his companion on his many journeys. Scholars have also identified St. Luke as the author of the companion volume, the Acts of the Apostles. Tradition says that Luke was never married and died at age 74 in Bithynia "full of the Holy Ghost." Traditions and speculation are abundant and varied concerning his later field of activity and place and manner of death.

It has been said that the Gospel according to St. Luke is the loveliest book in the world. It is the easiest of all the Gospels to be read and understood by the Gentiles because it was written by a gentile for the gentiles — people very much like ourselves. From it we are able to learn in some detail much about the character of the man who wrote it. Luke was known to be a scholar, well-versed in Greek language and Greek tradition. He was also something of a poet and possessed an artist's ability to depict in vivid pen-portraits the men and women who inhabit his pages. Legend has it that Luke was a skilled painter. There exists a painting of Mary in a Spanish cathedral which is purported to have been done by him. But he was a Physician by profession, and perhaps it is this which best explains the wide human empathy he possessed. It has been said that ministers see men at their best; a lawyer sees men at their worst; and a doctor sees men as they are. Luke saw men as they were and loved them all.

It is possible also to derive from study other characteristics of the author's mind and spirit. He was very broad in the scope of his sympathies, compassionate toward the poor and the outcasts of society, genuinely pious, self-effacing,

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charmingly urbane, and deeply loyal. He remained with Paul to the end, doubtlessly serving and helping him medically and in other ways. In so doing, he earned the Apostle's love, gratitude and admiration. Luke was more interested in people than in ideas. He had a lively social conscience and an inexhaustible sympathy for other people's troubles. He was extremely interested in the poor (not just the "poor in Spirit," as Matthew records). Luke's Gospel has been called the "Gospel of the underdog." His heart goes out to everyone for whom life is a struggle. Luke shows Jesus as the friend of outcasts, sinners, and the downtrodden. Luke, of all the Gospels, sees no limits and no restrictions to the love of God. His love is boundless, universal and unconditional. His theme is to make that availability and universality manifest to all.

Luke is symbolically or emblematically represented in the visual arts as a calf, a traditional animal for sacrifice. Luke saw in Jesus the Sacrifice for all the world and all people, for Jews and Gentiles, saints and sinners. It isn't difficult to see why Paul called him "beloved physician."

Given these precepts set out by Luke we can, if we will, apply his teachings and approach as we minister to the sick, friendless, and the needy today. These precepts are in keeping with the life's work of other medical giants down through the years from Aesculapius, Hippocrates, Schweitzer, Livingston and Osler - right down to the present day.

It is through our actions and integrity that Physicians may deserve-to be honored—not simply because we are Physicians. Ecclesiasticus says "Honor the Physician with the honor due him, for the Lord created him; for healing comes from the Most High. There is a time when success lies in the hands of Physicians, for they too will pray to the Lord that he should grant them success in diagnosis and healing for the sake of preserving life." While much is said of honoring the Physician, we as Physicians must constantly strive to prove ourselves worthy of honor.

Robert Louis Stevenson, in writing a "Eulogy for his Doctor," honors the profession as follows:

> "There are men and classes of men that stand above the common herd;
> the soldier, the sailor and shepherd not infrequently, the artist rarely, rarer still the clergyman;
> the physician almost as a rule. He is the flower of our civilization,
> and when that stage of man is done with and only to be marveled at in history,
> he will be thought to have shared as little as any in the defects of the period,
> and most notably exhibited the virtues of his race.
> Generosity he has, such as is possible to those who practice an art,
> never to those who drive a trade; discretion, tested by a hundred secrets;
> tact, tried in a thousand embarrassments and what is more important,
> Herculean cheerfulness and courage so that he brings air and cheer into the sick room
> and often enough, though not so often as he would like, brings healing."

We must keep foremost in our minds that to be honored is not our goal. There are invariably times when despite all our best efforts our patients' outcomes are not good—we've worked hard and felt that our efforts were unappreciated and that our task was a thankless one. On the other hand, it is very easy to get arrogantly puffed up sometimes when we are honored and praised because some desperately ill person survives and gets well, when if we are honest with ourselves, a lot of those times we don't really deserve that credit and have actually done little to alter the course of the illness; yet we are credited with and lauded for a miraculous cure. We must learn to accept both scenarios with equanimity and grace.

While knowledge and some degree of intellect are required to gain the fund of information essential to what we do, we must not permit it to make us arrogant, haughty, conceited, ego-inflated and unfriendly. It must be delicately and carefully balanced with humility, compassion, sympathy and a genuine caring concern for those entrusted to our care—those who we must consider it a privilege to serve. Medicine is not only a function of science but the successful practice of medicine is equally an art. Skills in communication with patients and their families must be developed. We must be able to show and communicate that we are concerned and really do care, no matter how late the hour, how poor or underprivileged the patient, how little the chance of getting paid for services, or how difficult the case, the patient or the family may be.

Natural ability and intellect, fired in the crucible of a vast fund of medical knowledge, tempered on the anvil of genuine love, compassion and service, and cooled in the clear waters of faith in One far greater than anyone or anything else forges our mission and our purpose here on earth.

Science plus art plus faith in and dependence on God, from whom comes all knowledge, power and healing, allow us to minister to our fellow man successfully and with immense satisfaction. Our purpose is not only to heal the body, but also to minister to the emotional needs of the mind and the spiritual needs as well- to give strength, solace and sustenance to the soul. Our aim is to restore the whole being. In recent years, a great deal of attention has been given to formal courses in ethics for practitioners of the healing arts. To me it is sad and absurd that such instruction must be formalized in the classroom. Ethics should come as naturally and instinctively as drawing that first breath. Such courses would be superfluous indeed if we could all see our task as it should be - largely, fashioned after the precepts set down in Luke's Gospel.

Why does one choose to enter a career in medicine or a related field? Everyone has slightly different reasons I'm sure. In closing, I would like to share with you, very nostalgically I fear, why I am here today. Please indulge me briefly.

In my hometown of about 3,000 people in rural Georgia, I grew up first on the knee and later by the side of my maternal Grandfather who began the practice of medicine there shortly after his graduation from Emory University's School of Medicine in 1906. Despite the fact that I had wonderful parents, I elected to spend literally all of my childhood that I possibly could with him. His influence on my life far exceeds that of any other living person. He taught me more than the public schools, not only facts and figures, but about life and dealing with other people. I toured the Georgia countryside making house calls with him. I first rode along and learned from him. Then, he taught me to drive and soon I became the chaffeur, and his teaching and my learning never ceased. He bought me my first car when I was a junior in medical school. He loved me, and I loved him and he loved medicine for all the right reasons.

He loved people, particularly the poor people, the underprivileged and the downtrodden and in turn he was loved by the people in his community as very few are today. He was a man with a deep and abiding faith. He did not seem an outwardly or ostensibly religious man, but he was! He didn't wear religiosity on his sleeve for all to see, but he lived it in his regard for those people around him. His efforts on behalf of the people he loved and served were tireless and unending. From his horse and buggy beginnings, he brought the first telephone lines into the county, setting up a switchboard in his own home in order to provide greater and easier access to the "Doctor." I never recall hearing my grandmother refer to him, even within the family setting, as anything other than the "Doctor." The practice of medicine was his vocation, his avocation and his religion. At our insistence, he finally retired in 1963.

My Grandfather died in 1966, a year after my graduation from Emory's Medical School. At the time of his death at age 86, he owned his home, an eight-year-old automobile and possessed one $20,000 CD. This is not much to show by our standards for 57 years of dedicated work, but he considered himself "rich" and he was very, very rich indeed. His treasures were not stored up on earth.

Like Luke, my Grandfather, "The Doctor", enriched the lives of all those around him.

For as long as I can remember, a framed prayer hung on his office wall. It was given to him on his birthday in 1943 by my mother and there it stayed until his office was closed in 1961. Since the time of his death in 1966 until today, it has had a place of prominence in my own office. May I share it with you?

Lord, who on earth did minister to those who helpless lay,
Guide now the Doctor who fulfills Thy Golden Rule today.
Give to his eyes the power to see the source of hidden pain;
Unto his hand the healing touch that makes faith whole again,
Give to his voice the ring of truth that comforts and brings cheer.
To every cry of anxious heart let him be swift to hear.
From Thy great store of wisdom fill his mind and give anew
Thy strength when hours are long and work seems more than he can do.
Lord, help him see, when tired and worn from thankless tasks well done,
That his good fight is honored still and bid him carry on.
He is Thy instrument; he stands for truth and good alone.
Lord, guide the Doctor, for his work is evermore Thy own.
(anonymous)

Ben Carmichael, M.D., FACC *is a specialist in Cardiovascular Medicine in Hattiesburg. He is a member of the MSMA Board of Trustees.*

Timely Filing of Death Certificates

Dear Editor:

I recently represented MSMA in a legislative conference regarding the streamlining of the filing of death certificates in our state. Charmain Thompson was also present at the meeting, along with key legislators as well as representatives of the Mississippi Hospital Association, Vital Records Department of the State Board of Health and the funeral home directors. Both Charmain and I were surprised to learn of repeated problems that the Vital Records Registration was having in obtaining compliance with timely signing of death certificates by physicians in our state. I won't take up space delineating the law regarding, the requirements for filing of death certificates as it is quite lengthy; however, to be brief the hospital is to obtain the certification and signature of the certifier [physician] and forward it to the funeral home within 72 hours of death. In cases where an autopsy is anticipated the word "pending," may be placed on the first line of the cause of death section.

The registrar of the vital records department gave two examples to us of cases where a particular hospital had only 28% of death certificates signed within 72 hours of death with one physician averaging 16 days to complete the certificate while other physicians averaged 15,14 and 11 days respectively. The second hospital had only 19% completed in a timely fashion with one doctor averaging 20 days for his/her signature. It was made clear that these were only examples of a statewide problem.

Family members must present a copy of the death certificate for insurance purposes, to obtain social security and veteran's benefits, to access safety deposit boxes, etc. In some of these cases the cause of death is not necessary, only proof of death. Obtaining certified copies of the fact of death is often crucial to the financial security of the family at a time when they are least able emotionally to handle additional burdens.

I realize that not all of these physicians are MSMA members, but also would urge our members to be cognizant of the true importance of timely signing of these certificates. It truly is an obligation that we as patient advocates and physicians owe to our patients and their families. Thank you.

Sincerely,
John J. Cook, M.D.
Jackson, MS

[Editors Note: See related news article, page 100.]

Dystonia in Mississippi- Educating our Physicians

Dear Editor:

Essentially, my entire medical career has been focused in Mississippi beginning with my graduation from the University of Mississippi School of Medicine in 1967 and ending with my retirement as an ophthalmologist in 1996. Retirement was precipitated secondary to disability resulting from cervical dystonia (Spasmodic torticollis). You can, therefore, understand that the health and well being of the people of Mississippi are vitally important to me.

The average time from onset of the cervical dystonia to the time at which an accurate diagnosis is made in the United States is just under seven years. In my case, the time interval was six years. These years are filled with intense pain and increasing disability and lifestyle changes for the affected person. One of the most significant reasons for this delay in diagnosis, I feel, is that physicians are generally by and large unaware of these disorders and do not include them in their differential diagnoses.

We are now in the stages of organizing a Mississippi Dystonia Support Group to provide support to dystonic Mississippians, as well as, help to educate our physicians about these disorders so that we can shorten the time interval from diagnosis to institution of proper therapy. This will save individuals an incalculable degree of physical pain and emotional suffering.

I am not unaware that we are all solicited for this or that group for our support, but I sincerely feel this is a major area of misdiagnoses. Even when I discuss this disorder with other physicians, most have not the slightest hint about this type of neurologic disorder.

Thank you for reading this letter and I assure you that any assistance or suggestions that you can provide us will be appreciated and used to help other Mississippians.

Sincerely,
William East, M.D.
Meridian, MS

[Editors Note: For more information on the different types of dystonia, a neurological disorder characterized by severe muscle contractions and sustained posture, contact the Dystonia Medical Research Foundation, ph.: (312) 755-0198, E-mail: dystfndt@aol.com. To find out more about the Mississippi Dystonia Support Group contact Dr. William East, ph.: (601)681-6661.]

Disagrees with Portrayal of Medicaid Situation in Mississippi Delta

As a general pediatrician in the Mississippi Delta, I looked forward to reading "Medicaid Misgivings" in the Dec. 15, 1997, issue of *AMA News*. I was somewhat surprised; however, by some of the assertions made in the article.

The notion that most physicians in the region do not see many patients on Medicaid is patently absurd. I do not pretend to speak for an entire area; but, I do know that the majority of the approximately 20 primary care physicians in my county, as well as all of our surgeons, see a large number of Medicaid recipients and are glad to do so. In my clinic, which consists of three pediatricians and one general surgeon, about 70% of our patients receive Medicaid. Indeed, one of my partners has twice written the Division of Medicaid asking to be allowed to see more Medicaid patients through the HealthMacs program, to no avail. These are our neighbors, and thus our patients.

A more likely reason than those mentioned in your article why some practitioners do not welcome Medicaid enrollees is the gross inefficiency of the system. Many of us would be quite content with the reimbursement rate if only Medicaid would actually pay us what they agree to pay. This program is notorious for rejecting claims for any number of bureaucratic and/or clerical reasons. I personally have more than 30 claims that have remained unpaid for more than a year - some for more than two years - pertaining to hospitalizations. I cannot count the number of office visits, immunizations etc., that are routinely denied for similar reasons.

As to the problems with HealthMacs: This is not a fundamentally flawed program and, indeed, has some merit; but your article was somewhat misleading.

For one thing, HealthMacs did not suddenly allow Medicaid recipients to have a primary care physician. They can see the same physician as easily as anyone else; as do my patients on Medicaid. Even with HealthMacs in place, a fair number of patients "assigned" to one physician will routinely see another as a result of various loopholes within the system.

The problems with emergency department visits are not as simple as presented in the article. Many of us are opposed to the current system, which requires primary physician approval for ED visits. This dictates that the primary physician attempt to triage the patient over the phone without benefit of direct physical examination. These patients are not allowed to be triaged by the ED physician, but must have our approval before the ED doctor can assess the severity of their illness. The risks to the patient, not to mention the liability to the primary physician, are potentially enormous.

Although I personally do not agree with the notion of blanket approval for ED visits (and pay the price nightly), I have a difficult time faulting physicians who do so, because of the risks to the patient.

Finally, I do not believe that the majority of us are opposed to Medicaid HMOs any more so than other HMOs. We do not like faceless bureaucrats making medical decisions about our patients and we object to yet another level of paperwork. Quite frankly, many dislike the notion of taking resources from patient care and transferring them to yet another group of middle managers.

Bob C. Tibbs, M.D.
Cleveland, MS

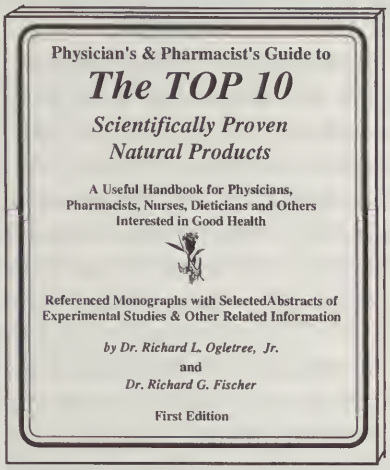
[Editor's note: This letter from an MSMA member was recently published in the AMA News and is reprinted here.]

Photos by Physicians on JOURNAL MSMA Covers Well-Liked

Dear Editor:

The first two covers featuring physicians' photography are awesome. I do hope that you continue this. It is a great source of pride in fellow physicians as well as great inexpensive cover art.

Chester C. Lott, Jr., M.D.
Starkville, MS



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Birth and Death Certification: MSDH Explains Terms

Physicians are often uncertain about the correct use of terms which must be employed in the filing of birth and death certificates with the MSDH, as required by law. It has become evident that there is confusion among medical records staff, as well as some physicians, about whether an infant is to be considered a live born child that dies almost immediately after birth, or a spontaneous fetal death, which means the infant was born dead.

"Live Birth" means the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes or shows other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

"Fetal Death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of duration of pregnancy; the death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles.

Medical Records staff are completing birth certificates based on the fact that there was some movement and/or breathing after birth. They are also noting on the birth certificate that the baby subsequently died, and the date of death. However, without checking with Labor and Delivery other Medical Records staff are determining that the same infant was a spontaneous fetal death because the doctor stated that the infant was "nonviable." In some instances a birth certificate, a death certificate, and a report of spontaneous fetal death are all completed for the same infant. In other instances only one record is filed and it may or may not be appropriate for the circumstance.

If the fetus did not breathe or show any other evidence of life, it is considered to be a spontaneous fetal death. This should be noted on the medical chart and should be reported on the appropriate form **IF** the gestation was at least 20 weeks and/or the weight was at least 350 grams.

When a death occurs in a hospital, regardless of the age of the deceased, the hospital is responsible for initiating the death certificate by completing the following items: Name of Deceased (item 1), Hour and Date of Death (items 3a,b), Place of Death (items 7a-d), and Pronouncement (items 22a-c), and then having the appropriate physician complete the CERTIFIER and CAUSE OF DEATH sections (items 23a-24d and 25a- 28). This should all be accomplished within 72 hours of the death, and the certificate should be forwarded to the funeral home which picked up the body. If there was no funeral home (that is, the body was released to the family, or it was a hospital disposal, etc.), the hospital is responsible for completing the ENTIRE death certificate and sending it to the Office of Vital Records Registration within 5 days of the death. Under no circumstance should a death certificate be given to the family.

Delays in the signing of death certificates by physicians can cause a number of problems for funeral homes and for the family of the deceased. Until the death certificate is received by the Office of Vital Records Registration, the family cannot get any certified copies, and thus cannot process insurance claims, settle estates, or take care of other legal affairs. Late filing of certificates slows down the processing of death records by Vital Records Registration, which in turn delays the submission of reports and data to the National Center for Health Statistics, Social Security Administration and other agencies. Thus it is very important that the hospital's portion of the death certificate, which includes the certifying physician's signature and the cause of death, be completed within 72 hours and sent to the funeral home, or, if there is no funeral home, that the entire death certificate be completed and sent to Vital Records Registration within 5 days.

When completing the CAUSE OF DEATH section of the death certificate, the physician should remember also that a new law regarding the completion of these records went into effect as of July 1, 1996, that states:

In the event that the decedent is a female, who at the time of her death was between the ages of ten (10) and fifty (50) years old, the physician, medical examiner, coroner or other official who certifies the decedent's cause of death shall indicate, where appropriately designated, on the death certificate whether (a) the decedent was pregnant at the time of her death; (b) the decedent had given birth within the preceding ninety (90) days; or (c) the decedent had a miscarriage within the preceding ninety (90) days.

This information should be listed in item 26 Part 11 of the death certificate.

-Bureau of Public Health Statistics, MSDH.

MSMA to Offer Principles of Documentation Workshop

As managed care becomes more prevalent, it is now more important than ever to have accurate and concise documentation in each patient's medical record. Proper documentation can protect the practice from fraud and control the cost of care. In this full or half-day program, participants will explore the various principles of documentation and record-keeping An additional course is also available which covers special documentation issues for teaching physicians.

In this workshop, participants will learn:

- how to correct patients' charts
- how to design and use consent and signature forms
- what should be in an operative report
- the guidelines for radiology and pathology reports
- correct documentation of E/M codes
- the rules for record retention
- Illegal issues concerning record release

Interested physicians, office managers, medical office staff, clinical staff, and billing personnel are encouraged to attend.

In order to fully participate in his workshop, registrants will need to bring their current CPT code books.

This program has been approved by the American Academy of Procedural Coders (AAPC) for three credit hours of continuing education.

Dates and sites are as follows:

June 6-10, 1998, Executive Inn, Tupelo
June 6-11, 1998, Holiday Inn Southwest, Jackson
June 6-12, 1998, Holiday Inn Coliseum, Biloxi

For more information call Debra Collins, (601)354-5433 or toll-free 1-800-898-0251.

Mississippi Psychiatric Association Annual Meeting to be Held in March

The annual meeting of the Mississippi Psychiatric Association is scheduled for March 19 through 22 at the Isle of Capri Hotel in Biloxi. Members of all specialty groups are invited to participate. The program will of fer ten to twelve hours CME presented by nationally known experts and cover a variety of topics. The final program will be announced at a later date. For more information or registration, contact Janis Borsig at 984-5808.

Evening Class: "Spanish for Medical Personnel" Offered for the First Time

Millsaps College is offering an evening Spanish class for missionaries, physicians, dentists, nurses, social workers and other medical personnel who want to assist Spanish-speaking patients. The course will teach essential phrases for emergencies as well as everyday situations. Students can expect to learn Spanish basic pronunciation, as well as language used in physical examinations, anatomy, patients' complaints, drug-related problems and other pertinent topics.

The course consists of five Tuesday night sessions, beginning March 31, 1998 (noncredit, no grades) from 6:00-7:30 p.m. The cost is $100 plus a textbook. This includes a phrase book and further reference information.

Prior knowledge of Spanish is helpful, but not necessary. Enrollment is limited.

For more information or to join the class contact the Millsaps Office of Adult Learning, phone: 974-1130.



1998 Health Issues Forum

The 1988 Health Issues Forum, sponsored by the Mississippi Hospital and Physician Foundation, a joint event of the Mississippi Hospital Association(MHA) and the Mississippi State Medical Association (MSMA), was held on Tuesday, January 13 at the Crowne Plaza Hotel in Jackson. The forum provided an opportunity for elected officials and those in the healthcare community to address legislative issues that affect health care.

Lt. Governor Ronnie Musgrove and Speaker of the House Tim Ford opened the program. Elected officials as well as other members of state administrative bodies served on a panel that addressed healthcare issues in Mississippi. Participating in the panel were Senate members Hob Bryan, chairman of the Senate Finance Committee, and Dean Kirby, chairman of the Senate Insurance Committee; House members Bobby Moody, chairman of the House Public Health and Welfare Committee, and Mary Ann Stevens, chairman of the House Insurance Committee; State Health Officer Dr. Ed Thompson; and the Director of the Mississippi division of Medicaid, Helen Wetherbee.

MSMA Director of Governmental Affairs Charmain Thompson and Vice President for Government Relations and Communications for the MHA Brent Alexandar concluded the program by outlining the legislative priorities for their respective organizations.

The major issues from the health and public welfare perspective for the 1998 legislative session were trauma care, the Child Health Insurance Proram, and the handling of funds from the tobacco settlement.

Speaking from experience, Lt. Governor Ronnie Musgrove said he appreciated the care that he received when he was in need of trauma care. "I have firsthand knowledge of trauma care in Mississippi," he said. "I appreciate the treatment that the medical community and healthcare providers gave to me personally that allows me to stand here today. But I also recognize that at some point in time, in a reasonable, appropriate manner, we need to make sure that we provide that kind of trauma care for all of our citizens."

Panel members agreed that the Children's Health Insurance Program was an excellent opportunity to provide for the well-being of the state's uninsured children.



(left to right) MSMA President Dr. H. Vann Craig introduced Speaker of the House Tim Ford and Lt. Governor Ronnie Musgrove.



State Health Officer Dr. Ed Thompson; House members Mary Ann Stevens, chairman of the House Insurance Committee, and Bobby Moody, chairman of the House Public Health and Welfare Committee.



Senate members Dean Kirby, chairman of the Senate Insurance Committee and Hob Bryan, chairman of the Senate Finance Committee, and Director of the Mississippi division of Medicaid, Helen Wetherbee.

Through the Budget Reconciliation Act of 2002, the federal government will provide $48 billion to provide health care to children through grants to the states. Mississippi can receive $260 million of this money by matching 16% of the federal funds with funds from the state.

Rep. Bobby Moody of Louisville said that the program was the "best opportunity to make sure every child in this state has access to adequate health care." The use of money received from the tobacco settlement was discussed, with the heaviest emphasis being placed on the immediate administration of the funds. Rep. Moody stated that he felt a health care trust fund that would place all of the funds received from the settlement into an account and would allow only the interest from the principal to be spent was a good solution for the immediate administration of the funds.



MSMA Director of Governmental Affairs Charmain Thompson.

State Health Officer Dr. Ed Thompson said one of the most important considerations was that the money be spent to improve the health of all Mississippians, with preventive health measures playing a key role. He also pointed out that the money should not be used in place of other funds, but should be used in addition to existing funds.

Other issues discussed during the panel presentation included Sen. Kirby's mention of Senate Bill 2215, which would require health insurance policies to cover the treatment of diabetes, and Senate Bill 2205, which would require health insurance companies to cover hospital dental care. Sen. Kirby went on to say that the input of members of the healthcare profession is greatly appreciated. **He stated specifically that healthcare professionals should call their senators and representatives and share how issues affect both themselves and their patients.**

Sen. Hob Bryan stated that one of the major issues that needed to take place in health care was a move toward prevention. "The system, it seems, is structured to reward for treatment rather than for prevention. There should be a change in the system to reward for prevention for the benefit of society," he said.

Helen Wetherbee, executive director of the Mississippi division of Medicaid, echoed Bryan's call for more rewards for preventive care and stated that the Medicaid program does not do a very good job of funding preventive care. Wetherbee went on to say that the



Vice President for Government Relations and Communications for the MHA Brent Alexandar.



Dr. Briggs Hopson, Vicksburg; Dr. Don Q. Mitchell, Jackson and District 25 Senator (Hinds and Madison) Dick Hall.

Medicaid program is 35 years old and is, in many ways, obsolete. "The worst thing about the Medicaid program is that it has created a second standard of care for Medicaid patients," she said.

With regard to the legislative agenda of the MSMA, Charmain Thompson called for strong support of Senate Bill 2192, which adds a phrase to the existing medical malpractice law setting a maximum time frame of seven years during which a claim of medical malpractice could be filed. In his comments, Lt. Governor Musgrove stated that the bill would be passed and the needed tort reform would take place.

Though the statute of repose for medical malpractice is the highest priority of MSMA, other issues such as charitable immunity for churches that provide free medical clinics and efforts for antitobacco legislation were also discussed. Scope of practice issues involving pharmacists, chiropractors, podiatrists, and optometrists are also a serious concern.

Brent Alexandar of MHA spoke concerning 23 legislative agenda items that had been approved by MHA Board of Governors. The first agenda item reflected the desire on behalf of MHA to prevent open meetings for hospitals and health systems. There is a current movement to open hospital board meetings to the public. Alexandar stated that opening board meetings to the public would undermine the confidentiality of the board of trustees in discussing important hospital matters.

Following the Health Issues Forum, a reception was held for the Mississippi Legislature and other special guests.







Top photo: *Dan Harrison, Chairman of the Mississippi Hospital Association; District 75 (Scott, Rankin, Smith) Representative R.L. (Dick) Livingston and MSMA President H. Vann Craig.* ***Middle photo:*** *Among those from Laurel attending the reception were District 88(Perry County) Representative Joe S. Ellzey, Dr. John J. McGraw, District 42 (Jones County) Senator Vincent Scoper.* ***Bottom photo:*** *District 16 (Clay, Lowndes, Oktibbeha) Senator Bennie L. Turner and Dr. John J. Cook, Jackson.*

Women Physicians - Women Legislators Meet



Left to right: Dr. Mary Gayle Armstrong, Women Physicians Caucus chair; Dr. Helen Turner, Vice-chair; Jane Reese Colburn, speaker; Dr. Susan Chiarito and Dr. Dwalia South.

MSMA Women Physicians met at the Crowne Plaza in downtown Jackson on January 16th before the annual MSMA/MHA Legislative Forum. The physicians introduced themselves and discussed plans for the next meeting of the recently formed MSMA Women's Caucus, which will be a breakfast meeting on Saturday, May 16th in conjunction with the MSMA Annual session in Biloxi. All MSMA women physicians are automatically members of the Women's caucus and are encouraged to attend he MSMA annual session in May.

The physicians were joined for lunch by female legislators and heard luncheon speaker, Jane Reese Colburn, Former Executive Vice-President of the National Breast Cancer Coalition and current Consultant to the National Cancer Institute. Ms. Colburn gave an interesting presentation on "Breast Cancer and Politics." This is a timely topic as the Mississippi Legislature discusses whether to match a Federal Breast and Cervical Cancer Grant during this session.



District 24 (Holmes and Yalobusha Counties) Representative Reta Eaves Holden and Dr. Don Q. Mitchell, Jackson.

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COMMUNITY HEALTH PARTNERS

AMA President-Elect Nancy Dickey, M.D. Visits Central Medical Society



Left to right: MSMA President-Elect Dr. Michael H. Carter, Jr., Central Medical Society President Dr. J. Patrick Barrett and AMA President-Elect Dr. Nancy W. Dickey.

Nancy Dickey, M.D., President-Elect of AMA, was in Jackson to address the Central Medical Society (CMS), February 3, 1998. While in town she also had breakfast with female members of the Mississippi Legislature, toured the University of Mississippi Medical Center (UMC) and the Jackson Medical Mall, spoke to UMC medical students, faculty and staff.

In response to Central Medical Society President Dr. J. Patrick Barrett's introduction, in which he characterized a high-energy, board-certified family physician from College-Station, Texas, who has risen the ranks of organized medicine to become the first women chosen to lead the AMA, not to mention a wife, mother-of-three, community volunteer and youth soccer league coach... Dr. Dickey responded, "Thank you, Pat, for those remarks. Frank, my husband, is a football coach. In fact, that is why I quit coaching soccer. In Texas when you are a football coach, your longevity in your job depends on how well you do; and he said that he had the most difficult job in the world because you put your job on the line every Friday night with a bunch of fourteen year olds in charge of breaking your back. He was having a really bad year, depending on which week of the season it was, it was 0 and blank. I didn't know anything about soccer; in fact, I still don't. I had some clue we had to get it to that end and put it in that little net down there; but these were five and six year olds and they knew even less which was okay. We were fortunately undefeated that season. It became very



Central Medical Society Officers left to right: President-Elect Dr. James R. House, III; Immediate Past-President Dr. E. Greg Wood, III; President Dr. J. Patrick Barrett, AMA President-Elect Dr. Nancy W. Dickey and Dr. Alan R. Peeples, Censor Committee.

strained at the dinner table. So I decided to go back to practicing medicine and let him do the coaching, and we worked out better that way," she said.

What follows is a transcript of the address she gave at the River Hills Club:

"I want to thank all of you. The Central Medical Society has put together a very busy but hopefully a productive day. Pat Barrett has been out since late last night to pick me up and early this morning to be my chauffeur. He is not only a fine leader for you, but he is a very fine chauffeur. You could get me a step. That Suburban is tough duty. Nancy Tatum escorted me around long enough for Dr. Barrett to go and play doctor for a while this afternoon and everybody has been most courteous.

I am also most impressed with the community. You have a fine medical community here that is extraordinarily exciting to be around and we should expect no less. When we look to states who represent the AMA, one of the places we point to is Mississippi. Your unified leadership sends a powerful message. More importantly, your percentage of membership sends a powerful message; and at a time we are struggling at best to hold our own in many states, they are indeed watching their numbers trickle even below that of the AMA members. It is very nice to look at associations and say 'What is it that you are doing because we want to clone it for the rest of the country?' Whatever it is you are to be applauded for that and part of it I am sure, both attributes to, is because of the successes you have been in your medical community. It has been a very nice day. I thank you for that Pat and for the invitation.

I want to address a couple of things. We do have a membership issue at the AMA. When I go to congress or when I talk to the media, one of

PROFILE: Nancy W. Dickey, MD

•**OCCUPATION:** President-elect, the American Medical Association (AMA); Associate Professor, Family Practice and Community Medicine, University of Texas Medical School at Houston.

•**AGE: 46**

•**EDUCATION:** Stephen F. Austin State University; University of Texas Medical School at Houston.

•**CAREER HIGHLIGHTS:** President-elect, AMA, 1997; Secretary-Treasurer, AMA, 1993-1994; elected to AMA Board of Trustees, 1989; Fellow, American Academy of Family Physicians; Vice President, Texas Medical Association, 1986-1987.

the questions they ask is 'How many of the physicians do you represent?' We have lots of answers for them. One is that we are the biggest physicians' organizations in the country, and that's true. Another one is our policy body represents 92 to 95% of the physicians in the country because we represent every state and 92 speciality societies, and that's true; but, every once in a while somebody will say to me - 'Yes, but what percentage of physicians do you represent?' and we have to say to them '40.' We would like to get closer to Mississippi's 60 or maybe back to 1960's 90%.

So I want to talk a little bit about what the AMA has done for you lately. Not because I have to convince you folks; but because I hope you will help provide the ammunition to go out and convince the other 40% in Mississippi and the other 60% around the rest of the country. AMA has been busy as Mississippi. Mississippi Medical Association has represented you well, and the two together have done good things.

Let's talk about tort reform. You just heard about the Statute of Repose. I've never heard it called that before. I keep thinking I should take a nap when I hear that. That has been one of the issues ever since I got out of medical school and got involved in organized medicine. In fact, it was the issue when I was involved as a resident and came into practice. Here we are - still struggling to get tort reform through the state legislatures and the national legislature. So some physicians say 'You haven't done anything on that issue.' Well, I am stating that we have done a great deal. We have given you some tools that we very much need you to use. We have gotten great changes in many, many state legislatures. Some of them - like Mississippi and Texas - have to change repeatedly because our State Supreme Courts take away that which we get periodically, and others have laws that have been in place. In fact, in California where we point to the MICRA Law, we have a problem because they say it has been there so long they now have a generation of physicians that don't remember what it was like to practice without MICRA. So when it is threatened now in the state legislature, they have a problem because they have young physicians that can no longer go and articulate the problem that may come about. So, we have to keep educating young 'docs' that it has not always been as good as it currently is.

One of the solutions is to get some federal reform. We have made progress even there. Many of you will recall there was a day we couldn't get it out of committee in Congress. So we go and give our money to candidates for Congress or for the Senate, and they can say to us, 'We are for you all the way.' Of course, they never had to cast a vote so we never knew for sure. What we did in the last two years is that we created a voting record - two in the House and one in the Senate. So, as you write your checks to support those people who are running this year or as your senators come and want to build their war chest for



AMA President-Elect Dr. Nancy W. Dickey and AMA Alternate Delegate Dr. Candace E. Keller, Hattiesburg.



AMA Alternate Delegates Drs. Nancy O. Tatum, Jackson and Mary Gayle Armstrong, Madison.



University Medical Center Associate Dean for Academic Affairs Dr. Helen R. Turner and Dr. John E. Moffitt, Chairman of the Medicine Plenary Program.



MSMA President-Elect Dr. Michael H. Carter, Jr.; AMA President-Elect Dr. Nancy W. Dickey, Central Medical Society President Dr. J. Patrick Barrett, and UMC Associate Dean, Professor of Surgery, Dr. Richard C. Miller.



Representative Dr. Jim C. Barnett, Jr., of Brookhaven and MSMA Director of Legislative Affairs Charmain Thompson.



MSMA President-Elect Dr. Michael H. Carter, Jr. and his wife, Mary Rose.

whenever they run again, I urge you to look at those voting records and make sure they put their vote where they put their words when you gave them the check two years, four years, or six years ago because we are going to keep on going back to Congress until we get some meaningful liability reform. The only way that will happen is for you and I to use the voting record that the AMA created for us.

We did something else that hopefully you will see has helped as well. Every time we have a liability push, the media comes out and slashes the headlines with horror story after horror story creating the picture that none of us competently goes to the office on any given day. Getting an opportunity to respond to some of those headlines became an arduous task because you always have to start by saying 'We are terribly sorry this happened' or 'Generally that is very safe.' So, one and one-half years ago, we began talking about some positive things we could do to make medicine progressively safer for patients. All of us are committed to having that happen. Nobody goes to work expecting or anticipating that there is going to be error or a bad outcome of some kind. We had a group of physicians who had put this on the pro-active list and have made a difference. The anesthesia group about twelve years ago formed an anesthesia patient safety group. As a result of the research that they did, the changes of technology they brought in, and the change of standards, there is virtually never an anoxic death in anesthesia today. Anesthesiologists have gone from virtually the highest level of risks in liability to the middle of the road. It is better for patients. It is better for anesthesiologists and physicians delivered it. We said, maybe we can learn a lesson from these folks. So, we - along with a broad based group of people including consumers, nurses, other physicians, people who had expertise in human performance - formed the National Patient Safety Foundation. This is not to replace tort reform. We are going to be in Congress every year until we get that, but it is to reassure patients that even as we look for tort reform to make it better for physicians to practice or care for patients, we want to be sure we are doing everything we can to identify systems of care that are a problem or places that have the potential for significant error and get rid of those potentials before somebody can become injured. If anesthesia is any indication, there is a huge amount of good that we can do. Over $5,000,000 has been contributed to the AMA from businesses and insurance and other institutes that want to see this research done. I think it will be a very exciting project. I urge you to stay involved, watch what is happening, and help make your community aware as changes come down the line.

Managed care - another favorite topic of medicine over the last few years. Managed care came about partly because of cost issues in medicine. In fact, I saw on somebody's shelf today a couple of copies of one of my favorite books, **Health Versus Wealth,** which talks about how managed care came about. There is a story in

there about a CEO who walked into a board room and pats his fist on the table and says 'No more double digit inflation in health care insurance. Find me a solution'- and managed care was suddenly off and running. I suspect it is a bit of an over signification but cost growth most brought this revolution and managed care has done some good things. We ought not forget that because it has done some things that are good for patients and good for 'docs'. It increased our accountability. It said it is no longer good enough to simply do it because that is the way we have always done it. It said 'Tell me what difference it makes whether you do that procedure.' 'Tell me whether you have compared treatment #1 or treatment #2.' These are probably questions we should have been asking ourselves for some time. The point is that we are now and it has been good for the practice of medicine. It has forced us to do a little better integrating of what each of us does in medicine. We are a pretty independent bunch of people and we kind of get going on our way until they forced us to do some integration and perhaps they forced more than they should have, but an ability to work together is probably good for our patients and it has happened quickly under managed care.

I don't have to tell you that it hasn't all been good with managed care. We have patients who are unhappy and doctors who are unhappy. We have probably more individuals approaching legislators, state and federal again, saying 'Fix this please' than they ever have had in the heath care arena. So the AMA has again helped those patients and physicians by a whole number of things. One is our legislative package. We got several things through last year known as patient protection things. We supported some length-of-stay legislation that demanded that insurance plans cover at least a reasonable minimum. We got rid of gag clauses, not only in state legislatures but in the federal legislature and began to educate legislators and the executive branch about the importance about not having declines of contracts that many managed care plans call for. Now, I can assure you that was just 'a nose under the tent,' if you will, of what is going to happen this year as even President Clinton has agreed to put forward a substantial number of additional patients protections. He has brought them about under his Quality Commission but many of them will be the kinds of things that physicians and patients have been asking for - for a long time. I would urge you to watch for those pieces of legislation to come about because just like Pat is asking you to be aware and call your state legislators there will be several opportunities this Spring for you to go educate and then later call upon and encourage votes from your national legislators on the kinds of legislation that will protect our patients in the managed care arena.

Secondly, even for the ones who have pretty decent patient kinds of services, we have some real issues with some of these contracts that physicians sign. Again, you have perhaps been somewhat protected here in Mississippi. There is less managed care contracting here than there is in California or Massachusetts but that means that you have a chance to hopefully learn from some of the problems that our fellow colleagues have had on the coast. One of them is the opportunity to negotiate a contract. I don't know how many of you read any news, but there was a litany of things in a recent Aetna contract that essentially was involuntary servitude of any physician who signed the contract. Aetna is one of the three biggest carriers in the country. The ability to simply say 'Forget it, I won't take care of Aetna patients isn't a real option for some physicians.' So, when no single physician can sit down at the table and honestly negotiate change because Aetna would simply say 'Fine doc, there are 300,000 where you came from,' instead, physicians in mass in the form of the AMA sat down with Aetna and said 'These contracts are simply not tolerable. There has to be due process. There has to be notification before you can simply take somebody off of the list. There has to be real utilization review. You can't call those things that are covered a medical necessity exactly the same. There are different issues in a contract.' In Texas, the contract has already changed. In Florida, negotiations are being carried on. Partly as a result of these negotiations, the AMA has now written a model contract that is available so you can either compare a contract that is on your desk or you can even go to a physician friendly insurer and suggest that this is a model for which they may want to draft their next contract rather than having to find themselves in court or at the negotiating table. That is something that lots of us in private practice, particularly if you are in a small group or solo practice, just don't have time to do. So the AMA and the organizations who represent you have attempted to do some of that leg work for you.

The third issue in terms primarily of managed care, but probably functional in other areas, is something called the Division of Representation. Again, as we look at medicine today, in twenty years it has changed so very much it is difficult to be a physician in a group of four or five when you are dealing with massive insurance companies, large contracts, and people who have a great deal more clout in the system than you do. Well, though we oppose unionization because unions embrace a philosophy of ethics that is very different from medicine, we believe that there is power in collective bargaining. So, the AMA last year formed a group, the Division of

Representation, who will come down to your town, to your medical staff, to your state and help physicians figure out how to form organizations that gives them the clout of collective bargaining without necessarily allying themselves with traditional unions and certainly without embracing concepts like going on strike to get what we want. We think that this is going to be a process that serves the physicians' needs and still preserves our professionalism. In Rockford, Illinois, we are watching this process being carried out now where a group of physicians have taken on a large physician management company and with the assistance of the American Medical Association look like they may be able to have substantial input into a change of relationships in a contract that no longer allows those physicians to care reasonably for their patients.

So, tort reform, managed care - lots of things on the agenda. I need to touch one more. E&M codes. You know those things that we document what we did today and send them off to the government that convert 45 minutes of difficult thinking and doing time to five or little digits some place. Let me go over where we are with those and how we got there because we have some wins here as well as some jobs for each of us to do. E&M codes got modified back when the first RVRS process went through attempting to correlate what we did in the office to the same kind of scale that we had re-correlated most of what physicians did. In order for doctors to understand the new Level 1, Level 2, Level 3, 99211, 99212, etc., they sent out some vignettes and said 'Here. It is very brief office visit here is what we think that might look like and here are three or four vignettes so you can compare what you did today, doctor, and take the right level of code.' Physicians said, 'uh,uh, wait a minute we have played with you guys before. We are not sure that we are going to read these vignettes the same way you read vignettes so how about you get us a little more information.' Well, be careful what you ask for - you may get it. They went back and re-wrote the codes. This time with fairly detailed instructions on what a Level 1, Level 2, or Level 3 kind of service would be. In fact, it was very easy when the new codes came out to know exactly what you had to write down in the chart if you were in a code or particular level. Except that people seemed to have forgotten that there was anything except generalist physicians who saw patients as a total. So in order to code a Level 5, the highest, most time consuming, most difficult level of office visit, you had to essentially do a complete physical on a patient who had some complicated diseases. Our speciality colleagues are with me 'I'm a cardiologist', 'I'm a gastroenterologist', 'I'm a rheumatologist.' 'I work just as hard but I may only do it for only a single or two body systems and this doesn't address our needs.' So, one more time we went back to HCFA for some additional guidelines. We said this doesn't meet our needs. Now HCFA has done two things in the interim as they came out with their newest set of guidelines. First, they consulted with every speciality association. So it is important that while you share your concerns with the Mississippi Medical Association and the AMA that you also share with your speciality organizations because some of our speciality organizations forgot to talk to us before they turned in their comments. So we need to be sure that we are all talking about the same things around the table. Secondly, HCFA came back with extraordinary detail this time. In fact, as many of you figured out looking at it, it is going to be very hard to spend enough time taking care of the patient because you have to spend all of your time taking care of the chart.

Let's talk about where that leaves us because I am very concerned. First, OIG audits of the offices are going to occur and even though we have gotten a six month window before the new codes have to be used, the audits aren't waiting. Beware, you could get a visit from an OIG auditor even before July 1 of this year. Now, you can pick when the auditor comes whether you want to use the old coding system or the new documentation guidelines, but you can't stop the audit from happening. That is important for us so we don't sit back and take a short nap or hit the snooze button until May or so. Secondly, the new E&M code guidelines, which are extraordinarily detailed, have gotten a six month delay so you won't be forced to use the new E&M code guidelines until July 1. If you haven't looked at the new CPT book, please get the book out and look at it and see what it means for your speciality and there are speciality specific guidelines that are in it. As you are reading it or as you are trying to use it over the next month or two, keep some very specific and detailed notations. Because we have a window of time to edit those guidelines but we need to know specifically what the problems and concerns are. Again, share those with your speciality organizations as well as they are in on the editing process for the next six months. It is going to be complicated; and even while we attempt to find some relief in the coding guidelines, it is important that we not sleep through our six month delay that has been established.

Then, finally, though we have an opportunity for some edits for some of the worse problems that you help us uncover about the new code guidelines, there is an over time editing process for all of the CPT guidelines because they are established with some assistance from the AMA and speciality organizations. So, even if you don't win

your battle between now and July 1, know to continue to notify your speciality association and the AMA because the CPT Editorial Panel meets on a regular basis and continues to edit the guidelines. Now, one of the answers a lot of doctors are saying is to just get rid of the guidelines - or better yet, why doesn't the AMA get out of the CPT coding process. 'This has been a real disaster,' doctors say, and it doesn't look like it is going to be a serious problem. Let's talk about what the alternatives are. We are going to have a coding system because payors, particularly the government payors are not going to read out our written diagnoses. We helped establish the coding system - not as a payment mechanism but so we could help keep information about what doctors were doing and we could have some epidemiologic kinds of information. It was only later that it became used as a payment system, but there are at least two other groups that have coding systems that every year try to convince HCFA to get rid of the AMA CPT system and use the 3M system or some other systems. A system that has no physician input and in which we have no opportunity to edit or change or even identify particular problems that occur. So as frustrating as this one is and as much difficulty that it will be for us to learn the new system, I think that we have to acknowledge that we would rather have a system in which we have input than a black box system that is totally foreign to physicians or physicians' input. We have to use our time very wisely in the next six months.

I think that there are a couple of things we need to do. First, if you can't tell for sure what is going on in your office, whether you would pass an audit or not, then I encourage the Mississippi Medical Association, working with the AMA, to find mechanisms for physicians to be able to get the audit to come in. It might be your PRO. It might be your liability group here in Mississippi. It might be a for-profit group, but you would like to know whether you are coding and documenting well. Iowa Medical Association worked with Blue Cross/Blue Shield and did this. They discovered that over 70% of physicians had serious problems that probably would not have met an OIG evaluation. That ought to be a terrifying number when you realize you are looking not only at fines but potentially at jail. Most of the problems weren't fraud. Doctors, as you and I know, are by and large not trying to defraud the government; but, there were very poorly documented charts. We need to help find our colleagues that need assistance, either going back to school to learn how to document or a class in good coding, not creative coding but how to code well in our offices; and we each need to be aware of who is doing coding and overseeing it in our own offices so that we can help one another. If we can find a way for each State Association to help audit our records, then we ought to be there before the OIG. We ought to be able to say - 'We have been in your office and your records look good to us. If the OIG comes, we will sit at the table with you and we will defend you' - or 'We found some problems, and you may want to go to a coding course before somebody comes in to audit you' or heaven forbid, 'We looked at your records and looks to me like you have a serious problem. You are defrauding the government. If you don't change your ways before the OIG comes, we will sit at the OIG's table because you are making life tough for every one of us.' Medicine needs to do that because we believe that we police ourselves. I believe that we would only find a tiny percentage of doctors who are actually defrauding, but we are going to find a lot of physicians who are fearful of the new codes because they don't know whether they are meeting the recommendations or not. A short window and a lot of work to be done, an opportunity to make it better, but I think we are kidding ourselves if we think it is just going to go away if we don't pay much attention to it for the next little while. It is an opportunity for us as physicians to help one another and to establish a process to both audit and identify those who may need that assistance.

There are other windows of opportunity and I want to take the next couple of minutes to share one of my visions with you. Getting away from the short term issues, if you will, to some of the longer term issues and I'll bring you a challenge. Then, if we have time, I would be happy to answer any questions, Pat. I told you a little earlier that I thought managed care left patients unhappy and doctors unhappy. I think the CEOs are about to be unhappy. Because if you look at the economics, the cost of health care is beginning to go back up despite the best efforts of managed care and others. So if everybody is unhappy with the existing system, it appears to me we have a window of opportunity to make some changes in that system. Now, the managed care system came about with virtually no physicians input. I am not sure whether we were in Washington arguing with Bill Clinton or where we were, but we have been reacting to the managed care system for almost the last decade, and if there is about to be some substantial change in the health care delivery system, then I think we ought to step up to the plate and offer our solution rather than waiting for the next fix and having to be reactive to it. I think that the window of opening may be relatively short so we are going to have to decide what our solution is.

Let me share with you a couple of things that I think need to be in this solution. The first is a recommitment to professionalism. As we look at society's response to

physicians today, I think there is some concern on their part about just where our profession is. One hundred fifty years ago, the AMA was formed partly because there were young physicians who said 'You know, I am not sure that doctors can tell the difference between physicians and snake oil salesmen,- that we have a lot of the same behaviors as not terribly reputable folks who are practicing next to where we were hanging our shingles.' So, they established a set of principles of medical ethics. For the last 150 years, one of the core reasons for the AMA existing was to update and expand upon the principles of medical ethics. Yet, today, part of the comments your state legislators hear or what we read in the papers is a concern for patients about whether we put our economics in front of our commitment to patients, about whether we would abide by a gag clause in a contract rather than give appropriate information to patients, concern on patients' part about whether physicians are willing to see the poor or not and basically an expression of distrust about whether we still practice the ethic that they believe we ought to commit to when we leave medical school. I think if we want to have the solutions to health care delivery systems, we have to first make sure we are living that professional ethic or the public is not going to pay any attention to us. Whatever we do, it has to based on a recommitment to a strong professional ethic that puts patients first. Make sure that we are not battling between ourselves over turf or economics. That's tough at a time when we are seeing changes that are threatening the economics and the incomes and the turf of many physicians but I think imperative or we will have no chance to have significant input. Let's assume that we have done that- that we have the trust of the public and that they believe that we are basing any system reform ideas on what is good for society. I think that it has to be a system based on choice. I don't think there is any word Washington has heard more often in the last decade than give me the opportunity to choose my physician, to choose whether I go to a primary care physician or a specialist, to choose the plan or the kind of insurance that I have. This is just not a 'one size fits all' country. Look out there at the parking lot. You look at almost anything and we show our diversity, and I think that we are going to do the same in the health care system.

Secondly, there needs to be individual ownership. Today we don't have choice because most of the time our plan is owned by our employer, and she or he or it chooses on our behalf. We can't even blame our patients for not being terribly responsible. They are just existing in whatever they were given. The individual needs to be able to choose it and the individual needs to own it so they can change it if it is not working for them. On the other hand, we have to stay committed, at least for a significant period of time, to employer-provided insurance. Because of the way insurance developed in this country, 40 years of wage increases have gone into health care coverage. So if tomorrow we said 'We will provide insurance some other way and walked away from employer-provided health insurance, every employee would walk away from forty years of wage increases unless magically every CEO is suddenly going to convert those insurance premiums into wage increases.' I seriously doubt that is going to happen. So I think we are going to have expect that for at least for a significant transient time it would be employer-provided, but it ought to be individually owned. We are going to need our state legislators and our federal legislators to make some changes so that can happen. Because right now because of tax coding, the employer owns it, it is the employer's money, the employer takes the tax break, and he or she gets to make the choice on our patients behalf. So I am willing to concede that employers need to have budgetability. They need to have some predictability. I have some sympathy for the guys who are looking at double digit inflation in their health care insurance. I provide insurance for sixteen residents and substantial staff and when they go up 10 to 15% on me it hurts and if I don't know it until it suddenly arrives on my desk, I can't plan for it in a budget. But we can do that by going to a defined contribution like the federal government does. Say, here, 'I'll pay this much toward your health insurance, now you pick the plan that works for you.' It may be a plan that is completely covered by my contribution. It may be a plan that you have to contribute out of pocket. You choose what fits you. You own the policy but I will make a defined contribution to your coverage.

Then, lastly - all that stuff before you have heard before - choice, individual ownership, budgetability, defined contribution - one other piece I think has to go in and this is policy. The policy for over a decade at the AMA was kind of hidden. We don't talk about it much, and we don't go to the federal government and put this on the top of our list. I think it is time for physicians begin to demand that every American should have access to a reasonable amount of health care that they need and some preferably some form of coverage to pay for it. So, I don't want to have a nationalized health insurance plan. Heaven forbid any more Medicare or Medicaid and I think all of us will have to go find a different way to practice medicine, but I do think that we can find ways to extend coverage to every American. You are making some steps here in Mississippi with your extension of Medicaid by



college age kids and say to them, 'If you can't provide proof of coverage then for a minimal fee tagged onto your tuition we could cover you.' We as physicians ought to use our resources to identify the 15% of, the 40,000,000, Americans who are not covered and we ought to be using our clout to make sure that they are covered. Americans right now are perfectly willing to rely on your professionalism and say, of course they are covered, doctors don't turn them away. Hospitals aren't allowed to turn them away and instead of getting them care where they ought to get it - in a continuity fashion with a case of the chronic diseases, we end up caring for them in the most expensive places with them not getting the kind of care at the place and time that they ought to have it, and I think we ought to be using our voice on their behalf because it fits in with all of those concepts of professionalism.

It's a big agenda. But, it is an agenda that serves some of our issues because it is good for the patient in the long run."

At the conclusion of Dr. Dickey's address, Dr. J. Patrick Barrett presented her with a piece of Gail Pittman pottery with appreciation on behalf of Central Medical Society.

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Clinical Improvement Projects: Addressing Health Improvement and Cost Effectiveness

The basic approach used in clinical improvement projects (CIPs) is to measure and attempt to change *over time*, a practice or process related to clinical care that RCTs or other clinical research studies have demonstrated will improve overall patient outcomes such as mortality, readmission rates, quality of life, etc.

We at the Foundation call these key practices or processes **quality indicators,** and in the main we concentrate on measuring and improving them. The assumption is that if the right services are provided at the right time and in the right way, to the right patients, that overall outcomes will be improved. Clinical trials and other clinical research have proven this relationship, and some have even labeled it "evidence-based medicine."

In an effort to measure the impact of clinical improvement projects in New York State, the New York Quality Improvement Organization (IPRO) has developed a method to measure the impact of CIPs using two types of measurements. One measure is to estimate the number of quality life years saved resulting from the project, and the other is to measure the savings accruing to the health care system from the project.

The IPRO conducted a study of three projects measuring the performance of both parameters of health improvement and cost savings. One study analyzed the health and cost impact from use of anticoagulant and anti-platelet agents in atrial fibrillation.

The project is based on the strong scientific evidence that the use of anticoagulants (warfarin) or anti-platelet agents (aspirin) for patients over age 65 with atrial fibrillation will reduce the incidence of stroke among these persons. Aspirin is less effective in preventing stroke (22% reduction) but somewhat cost-effective in the younger age group (65-70) since the stroke incidence is lower than in the older age groups with atrial fibrillation and aspirin therapy is low-cost. Warfarin on the other hand is far more effective in the over 70 age group (68% reduction) and although it is more expensive, it remains cost effective since stroke incidence increases with age for patients with atrial fibrillation.

The IPRO used selected scientific studies to measure the reductions in stroke and to estimate the offsetting "costs" resulting from increased risks of intracranial hemorrhage and other bleeds for patients on warfarin. They included analysis of the total economic costs from a stroke and the offsetting costs of managing large numbers of patients on warfarin or aspirin.

Interesting points from the study include:

1. Risk reduction for stroke is 22% for atrial fibrillation patients on aspirin and 68% for those on warfarin.

2. Risk of hemorrhage from therapy age 65-69 was 1.47% per year from warfarin; 97% per year from aspirin and 89% for those on no therapy.

3. The project resulted in a 13.8% increase for use of warfarin and a decreased use of aspirin by 11.5%. Change in practice was primarily in the switch from aspirin to warfarin.

4. Projecting the practice change to all hospitalized patients with atrial fibrillation in New York State, the project would result in annual savings of 475 quality life years saved and a net annual savings to the health care system of 1.3 million dollars.

Recently, quality improvement organizations nationwide have been encouraged to assess the impact of their quality improvement activities on both health improvements as well as the cost savings resulting from their

projects.

In the past, we at the Foundation have concentrated solely on health improvements and not on cost savings. We will take up the challenge and follow the national trend. We will begin addressing the issue of cost savings in addition to health improvements in ongoing and future projects. We currently have a quality improvement project on atrial fibrillation underway in Mississippi. Preliminary results show a 13% increase in warfarin usage (same as observed in New York State).

When our final numbers are in, we will use the IPRO model to estimate our savings. They will be less than New York's since we have smaller numbers of patients but, over time, a reduction in the number of ischemic strokes will be significant. The IPRO model suggests that this will both improve the quality of life for many patients and result in a significant cost savings to the overall health care system.

Will all clinical improvement projects be both cost effective and also improve the length and quality of life? In a perfect world the answer would surely be yes. But realistically, some projects may accomplish improvement in quality and length of life; others may mainly save costs. Some projects will accomplish both goals and yet, some may not be successful in either.

As Mississippi's quality improvement organization, we at the Foundation will strive for success in our clinical improvement efforts, and in the spirit of continuous quality improvement when we fall short of our goal, we will use the experience to improve future projects.

Alton B. Cobb, M.D., M.P.H.
Clinical Coordinator

This article is a direct result of the Health Care Quality Improvement Program initiated by the Health Care Financing Administration, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore required no special funding on the part of this contractor. Ideas and contributions to the author concerning experience in engaging with issues presented are welcomed.

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Jackson Medical Mall Foundation Welcomes UMC Primary Care and Specialty Clinics



The opening of the University Medical Center's (UMC) Primary and Specialty Care Clinics at the Jackson Medical Mall marked the first time in history that the institution has had such a major presence away from the 164-acre medical campus. With the relocation of the UMC health clinics and an array of other services, the Jackson Medical Mall brings people and a community in need of healing a giant step closer to attaining a state of well-being. It also brings closer to fruition a two-year, $25 million dollar renovation effort and a dream for the Medical Mall's visionary founders.

The concept of the Jackson Medical Mall was initially proposed by Dr. Aaron Shirley, former project director of the state's largest community health center. Dr. Shirley teamed with the University of Mississippi Medical Center to form a plan to coordinate primary and specialty ambulatory care to serve Medicaid and Medicare-eligible patients and the medically indigent in the nearly vacant Jackson Mall shopping center.

One-Stop Shopping

With a broad range of agencies and retail establishments occupying about half of the Mall's 900,000 square feet at the end of the first construction phase, the Jackson Medical Mall expects to become an incomparable one-stop shopping center for people who often have multiple barriers to attaining much-needed services. UMC, the largest anchor tenant, began serving patients in its outpatient clinics in the fall of 1997. Grand opening ceremonies were held in January for their 45,000 square foot primary care clinic and their 165,00 square foot specialty care clinics.

Primary Care Clinics

The primary care clinics, a new concept for UMC, are located in a space directly across the concourse from the specialty clinic area. The concept of a multi-disciplinary primary care clinic evolved from collaborative efforts among UMC's clinical departments providing primary care, including family medicine, internal medicine, ob-gyn, pediatrics and sick-baby care.

Dr. Hursie Davis-Sullivan is assistant professor of family medicine at UMC and medical director of the primary care clinics. She feels that the close proximity of these clinics will offer patients an enhanced level of care. Unlike the specialty clinics, the primary care clinic does not have an existing patient roster because it's an entirely new concept at University Hospitals and Clinics (UHC).

It has no precedent on the medical center campus. Dr. Davis-Sullivan says, "We'll have 10 physicians and a nurse practitioner waiting to see patients. All my life, when people have told me what they want their doctor to be like, these are the doctors they're talking about," she said. Patients may choose which type of doctor they want to see- family physician, pediatrician, obstetrician-gynecologist or internist. Any patient may come to the primary care clinic. Acting as "gatekeepers" the primary care physicians will refer patients to the specialty clinics.

Specialty Clinics

The specialty care clinics are located on the first two floors of what was the Gayfers department store area at the old Jackson Mall. The specialty clinics offer a broad range of outpatient services including arthritis/rheumatology, cardiology, communicative disorders, dental/oral surgery, endocrinology, ENT, dermatology, general medicine, hematology, obstetrics and gynecology, pediatrics for at-risk mothers and infants, oncology, ophthalmology, orthopedics, psychiatry, radiology, rehabilitation services, urology, pulmonary and cardiac rehabilitation, geriatric rehabilitation, minor surgical procedures, surgery follow-up clinics, and an adult day care center.

> "Our mission is to foster a holistic approach to health care for the underserved and to promote economic and community development in the Jackson Mall area."
>
> -Mission Statement of the Jackson Medical Mall Foundation

Guiding the transition of the clinics to the Medical Mall is Primus Wheeler, UMC's Director of Ambulatory Services. Mr. Wheeler has overseen a smooth move and anticipates a high level of patient satisfaction. "When patients see how pleasant the surroundings are," he says, "we won't have any trouble with patient volume."

Patients visiting the clinics at the Medical Mall have access to almost unlimited free parking. Disabled patients can be dropped off near their clinic destination at any of several handicapped-accessible entrances. Generally, patients enter at the Bailey Avenue entrance and park on that side of the mall. Employees park and enter from the Livingston Avenue side.

Health Services

The proximity of services will facilitate timely patient care and increase patient compliance with appointments.

Health care at the Jackson Medical Mall will be afforded to a wide range of patients. They will be treated in clinics managed by different agencies, but their care will be coordinated from a case management perspective with linked data flowing between primary care and specialty providers. The proximity of services will facilitate timely patient care, and same-day, same-site referrals are expected to increase patient compliance with appointments as the need for transportation, often a barrier to keeping appointments, will be reduced. With a focus on prevention, health promotion and health education, and wellness services will also be available.

Other New Clinics

The Jackson Medical Mall Children's Clinic, the initial service of the Primary Care Clinic, opened in June, 1997. The Children's Clinic offers well-and sick-child care for infants through children age 18. Services include EP/SDT screening and immunizations. Pamela Confer, director of public relations for the Medical Mall said, "One of the benefits of the Children's Clinic is their ability to offer 'cradle to age 18' health care, where the mother sees the same physician for her child, which is especially important for teen mothers who may need more guidance."

The Hinds County Health Department also opened in June, 1997 in a new 20,000-square foot clinic. Its clinic offers prenatal and well-child care; hypertension counseling and treatment; immunizations; tuberculosis screening; family planning; ultrasound, dysplasia and NST; and walk-in screening, treatment, and counseling for patients with sexually transmitted diseases.

"Both the Primary Care Clinic and the Hinds County Health Department will coordinate patient care with the University Medical Center's specialty clinics," Dr. Davis-Sullivan said.

Other new health services at the mall will include a diabetes education and treatment center staffed by the endocrinology division of the Department of Medicine. Two diabetic education specialists will be on duty with at least one of them certified in foot care.

As the health care partners become operational, they will eventually be linked through a computerized data network enabling records to be shared. Shared data will translate into cost savings and improved quality of care as there will be reduced duplication, on-line access to information, and enhanced responsiveness. The shared data base will also become an important evaluation component in epidemiological studies.



The entrance to the UHC Primary Care Clinic.



The 20,000 square-foot Hinds County Health Department opened in late June of '97, offering a range of services including preventive care for pregnant women and children.



The STD/HIV Clinic of the Hinds County Health Department was designed without windows for confidentiality purposes. The average number of two HIV cases diagnosed each day are referred upstairs to the office of Project Connect which offers HIV/AIDS education and prevention programs and support groups.

Retail and Consumer Service Tenants

The Foundation maintains leasing arrangements with tenants throughout the Mall and on the property.

With a priority given to ensuring that the service, retail, and commercial businesses complement the health care services, the Jackson Medical Mall Foundation maintains leasing arrangements with tenants throughout the Mall and on the property, as well. In sum, the Jackson Medical Mall has brought together under one roof the resources required to improve significantly the quality of life for thousands of Mississippians. The goal was to establish the state's first "one-stop shopping center" for health care, human services, and other consumer needs for low-income residents.

City Services

Occupying 30,000 square feet of space, the City of Jackson has located two major departments on the south corridor of the Mall. At the City's Water/Sewer Administration the public can pay bills, apply for service, and request service transfers. The City's Human and Cultural Services runs programs which strengthen and nurture families and youth including the mayor's Summer Youth Job Initiative, the Social Work Referral Program, the Teens Take Charge of Your Life Program, and volunteer recruitment.

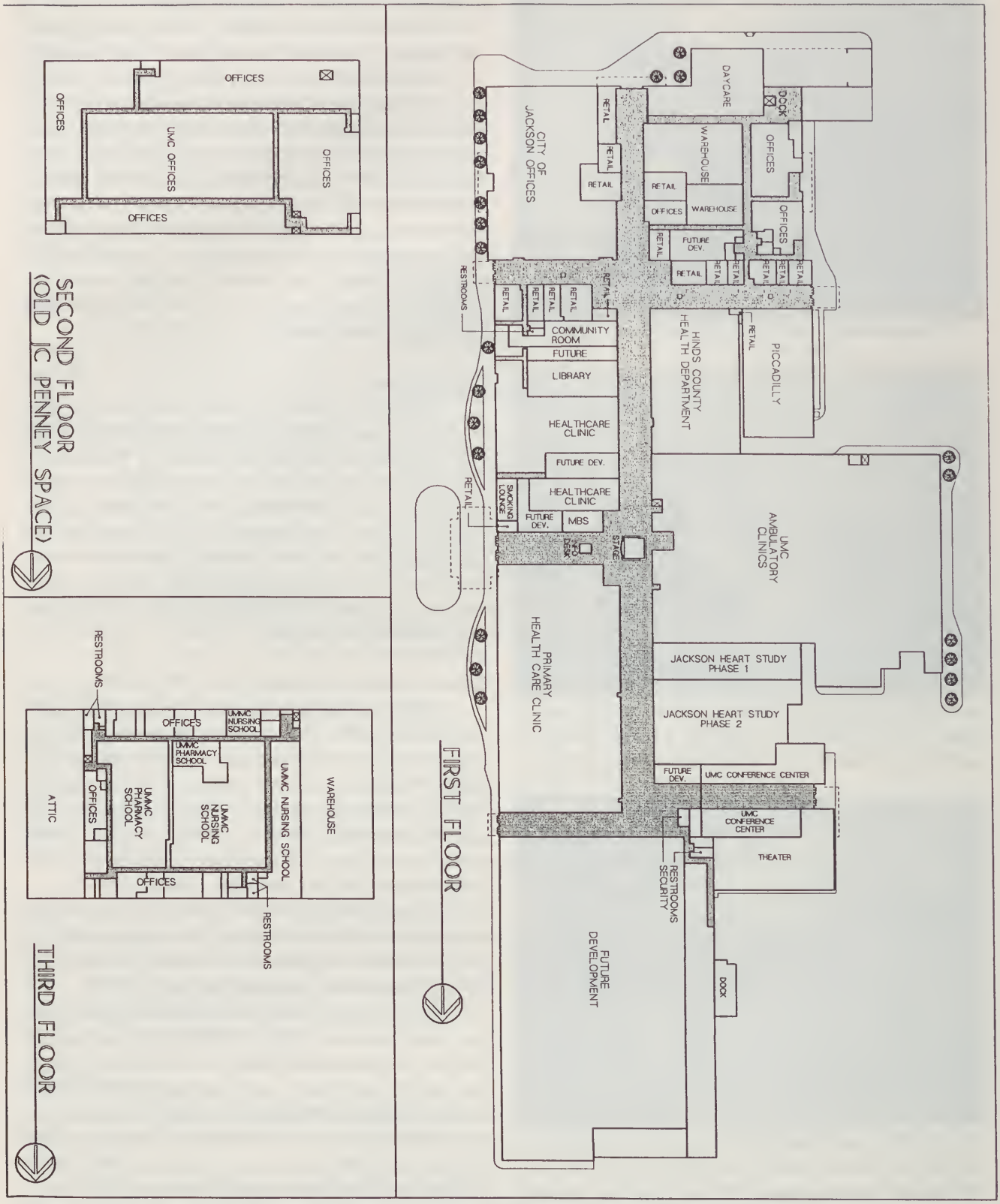
Retail and Other Services

Other retail and service establishments on the south corridor include Your Service Place, a convenient place to pay electricity, phone, gas, and cable television bills; Shear Talent, a beauty, barber, and nail salon; Domonique's Boutique, featuring ladies' and girls' clothing and accessories; Howard's Shoe Hospital, a shoe repair business; Davis Music Studio, offering music lessons; a snack shop and Piccadilly Cafeteria.

Lease agreements are in negotiation with a provider of day care services, to be located in the south corridor, as well as another restaurant and Mississippi Blood Services, to be located in the main entrance corridor.

The University child care center for patients, also new, won't open until July. It will be free to any patient who has an appointment that day and will be staffed with four nurses' aides and a unit secretary. The adult day center, a program of the geriatric division of the Department of Medicine, now on Insurance Center Drive, will also be a part of the mall's array of services. The Jackson Medical Mall Foundation board also has a child day care center for mall employees, patients and patrons under consideration.

Tenants located on the Mall property include Super



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Your Service Place, a bill payment center for electricity, phone, gas, and cable television bills, offers numerous business services. Customers can also pay their water and sewer bill across the hall.



Domonique's Boutique, featuring ladies' and girls' clothing and accessories is located outside of the former JC Penney Co., Inc.

Valu grocery, Rally's drive-through restaurant, and City of Jackson Police Precinct 3.

Goals and Strategies

The goals developed by the Jackson Medical Mall Foundation's Board of Directors during its strategic planning process involving community leaders, elected officials, and health and social service providers, further articulate the Medical Mall's initiative.

•To promote greater access to cost-effective, high quality health care for the under-served in Mississippi.

•To facilitate integration of human service delivery with health care delivery.

•To stimulate economic and community development in the area surrounding the mall.

• To utilize health care delivery activities to enhance educational opportunities.

•To build the financial strength of the Foundation to ensure future reinvestment in the community.

Community

Health status indicators suggest that the population in the Mall's service delivery area is at significant risk for poor health outcomes.

Located in the City of Jackson's Federal Enterprise Community Designation, the Jackson Medical Mall serves a population that, according to the 1990 Census, is 95.8 percent African-American and has a median family income of $16,651. The poverty rate of the area is 40.7 percent, and the unemployment rate is 16.4 percent.

Health at Risk

Several health status indicators suggest that the population in the Mall's service delivery area is at significant risk for poor health outcomes.

According to the Kids Count Data Book, 1994-



The City of Jackson Water and Sewer Administration, located in the southeast corridor, allows customers to conveniently take care of their business.



The City of Jackson Human and Cultural Department directs programs to strengthen and nurture families and youth.



Howard's Shoe Hospital was located in the Jackson Mall when it was Jackson's first shopping mall. Tenants like where they work. In judging the general appearance of the Medical Mall, 97% gave a positive rating, with 18% describing it as "excellant."

Medical Mall Tenant Profile

City offices, service establishments, restaurants, and retail shops are located in the Mall for the convenience of employees and the public. Priority is given to businesses that complement the Mall's health care providers.

CITY OF JACKSON

•**Water/Sewer Administration,** allows the public to pay bills, apply for service, and request service transfers.

•**Human and Cultural Services Department,** directs programs to strengthen and nurture families and youth.

RETAIL AND SERVICE ESTABLISHMENTS

•**D&G Communications,** a news and snack stand (Monday-Friday 8-5)

•**Davis Music Studio**, offering private music lessons (Tuesday-Friday 2:30-8, Saturday 8:30-3)

•**Domonique's Boutique,** featuring ladies' and girls' clothing and accessories (Monday-Saturday 9-6)

•**Howard's Shoe Hospital,** a shoe repair shop (Monday-Saturday 9-6)

•**Piccadilly Cafeteria,** a longtime Mall feature (7 days a week, 11 -8:30)

•**Save-A-Buck and More,** a discount specialty store (Monday-Friday, 8-5:30)

•**Shear Talent**, a beauty, barber, and nail salon (every other Monday 8-12, Tuesday-Saturday 8:30-6)

•**Shelby's,** a snack shop and cleaner's drop-off (in by 9 a.m, out by 5 p.m.)

•**Your Service Place**, a bill payment center for electricity, phone, gas, and cable television bills (Monday-Thursday 8:30- 5:30, Friday 8:30-6, Saturday 9 -1)

•Coming in the spring- shops for shoes, flowers, medical equipment, and uniforms plus a new restaurant.

ON THE MALL GROUNDS

•**City of Jackson Police Precinct 3**

•**Rally's Hamburgers**

•**Super Valu Grocery**

•Coming in the spring- **American Medical Response**

HEALTH CARE PROVIDERS

•**Hinds County Health Dept.**

•**UMC Specialty Care and Primary Care Clinics**

•Coming in the spring- **MS Blood Services**

THIRD FLOOR OFFICE CENTER

•**Medical Mall Foundation offices**

•**Associated Business Enterprises,** a temporary services agency providing clerical support to the Foundation and other clients.

•**Eliza Pillars Registered Nurses Association,** a social and professional organization of African-American nurses in Mississippi.

•**First Call For Help**, a 24-hour crisis phone line and referral and counseling service, a program of the United Way of the Capital Area.

•**Mississippi Health Advocacy Program,** an outreach project of the Catholic Sisters of Mercy.

•**Project Connect,** a referral and support center for patients living with HIV/AIDS and their families.

•**UMC School of Nursing**

•**UMC School of Pharmacy** (second and third floor)

1996, a publication of the Annie E. Casey Foundation, Hinds County has a low birthweight rate of 12.4 percent compared to the state's overall rate of 9.8, which is the lowest in the nation. The infant mortality rate for the county is 11.2 per 1,000 live births, also the state's rate, again the lowest in the nation. 18.1 percent of the births in the county are to single teens, higher than the state's rate of 17.7 percent, also the highest in the nation.



With a focus on wellness and prevention, the mall concourse already has mile markers posted for indoor walking.

More Risk Factors

According to Mississippi Trends, A Report on the Behavioral Health Risks of Mississippians, prepared by the Mississippi State Department of Health, over 25 percent of the aged 18 and over population of Public Health District V, which includes the Jackson Metropolitan Area, is at risk for hypertension. Coronary heart disease, stroke, and renal disease increase with undiagnosed and untreated hypertension. Risk factors include obesity, high alcohol intake, a high sodium diet, and physical inactivity. Higher frequencies of hypertension were observed among minority, female, senior, undereducated, and lower income subpopulations.

Mississippi Trends also reports that this central Mississippi population is at risk for such other adverse health indicators as being overweight (27.6 percent), sedentary lifestyle (65.8 percent), smoking (18.4 percent), and acute drinking (10.2 percent).

The State Health Plan for 1996-1997, developed by the Mississippi State Department of Health, reports that new tuberculosis cases in Mississippi have exceeded the national average for 35 of the last 36 years, with more than twice as many new cases reported among the nonwhite population as among the white population. Hinds County's rate exceeds the national average.

A One-Stop Shopping Center

For Jackson's urban poor with unmet health needs and those patients of the specialty ambulatory clinics of the UMC, the Jackson Medical Mall represents a new dimension in the availability and accessibility of quality, affordable health care under one roof. The Jackson Medical Mall Foundation is committed, however, to ensuring that service delivery means more than just the assembly of various agencies in one location.

Holistic Approach

Collaboration among the providers located in the Mall, coordinated through the Foundation, will assure that the complex and comprehensive health and social service needs of patients are addressed in an integrated, efficient, cost-effective, and holistic manner. Monthly meetings among health and human service agency tenants will address concerns regarding service delivery and facilitate interagency planning.

Patient satisfaction surveys will be routinely conducted so that quality of care evaluation can include how well the system is operating from the patient perspective.

One-stop shopping, according to The National Commission To Prevent Infant Mortality, is a strategy that coordinates and integrates health and social services so that the system can be accessed at a single point of entry. It should help locate, enroll, support, motivate, educate, advocate, and provide services to those in need. The Foundation will have the responsibility for addressing each of these action components and for identifying the resources necessary to bring them all into full implementation.

Historic Challenge

The concept of service integration and collaboration

is not a new idea. In 1971, then Secretary of Health, Education and Welfare, Eliot Richardson said "service integration is not a new program to be superimposed.... rather is it a process aimed at developing an integrated framework." However, one-stop shopping has been difficult to implement because existing programs are administered by multiple agencies with multiple funding streams, different eligibility criteria, and different covered benefits.

The current climate of change in the way health and human services are delivered creates the opportunity for the Jackson Medical Mall to institute this paradigm of integration for the first time in Mississippi. And the state of confusion that many low income clients find themselves in today with regard to welfare reform, health care reform, and managed care, heightens the urgency of the need for such coordination and compels the Foundation to action.

Office Activities

Upstairs in the Mall's Office Center are the Foundation offices, the Mississippi Health Advocacy Program, an outreach project of the Catholic Sisters of Mercy; Project Connect, a referral and support center for patients living with HIV/AIDS and their families; the Eliza Pillars Registered Nurses Association, a social and professional organization of African-American nurses in Mississippi and Associated Business Enterprises, providing clerical support to the Foundation as well as other clients.

The chief tenant on the third floor, occupying over half the available space, is the University of Mississippi School of Nursing, the temporary home for 60 faculty members and 400 students for the next 8 months while its existing facilities on the main UMC campus are being refurbished.

In mid-August, 1997, the fifth-year program of the University of Mississippi School of Pharmacy moved into its 11,000-square foot headquarters at the Medical Mall.

Educational Opportunities

At the mall students will participate in internships as well as have actual practical experience as an extension of their classroom work.

With three major institutions of higher learning as partners, the Jackson Medical Mall will provide enhanced educational opportunities for the students of Tougaloo College, Jackson State University, and the University of Mississippi Medical Center.

Service Opportunities

Tougaloo College , a four-year historically black liberal arts institution located six miles from the Jackson Medical Mall, anticipates that the Mall will offer many opportunities for students to fulfill their 60-hour community service requirement.

Among programs under consideration is an after school tutoring service for at-risk students living in the Mall neighborhood. The service would be operated by Tougaloo education majors. Other programs include internships for pre-med students, and an extension of the college's small-business entrepreneur resource center. Tougaloo also expects to have a link between the Jackson Medical Mall and its proposed on-campus health and wellness center for the elderly.

Jackson State University, the state's only comprehensive urban university, plans to expand learning activities for students studying in such fields as allied and public health, social work, speech and hearing, and health care administration to the Medical Mall. At the Mall students will participate in internships as well as have actual practical experience as an extension of their classroom work. Jackson State also anticipates that the Mall will offer a setting for satellites of its drug and alcohol studies and AIDS awareness programs.

Health-Related Learning

With increasing need for clinical experience for its medical, dental, pharmacy, and nursing students as well as those studying health-related professions, the University of Mississippi Medical Center expects that the Jackson Medical Mall will provide an optimum learning environment. As all UMC outpatient clinics become operational at the Mall's new facilities, the 120,000 patients currently seen annually in the clinics at UMC (in space designed for 40,000) will likely increase. The Medical Mall will also offer opportunities for continuing education, especially through UMC's Conference Center equipped with the latest in educational technology for distance learning.

Throughout the Mall, exhibits for children as well as adults will promote healthy lifestyles and share health education tips. Programs of consumer health and patient education will also be offered.

Focus on Minorities

The Mississippi State Department of Health's State Health Plan for 1996-1997, suggests ample reason to focus on the minority community in order to close the disturbing disparities between the health status of blacks and whites in Mississippi.

Health and Economy

The Jackson Medical Mall, with its focus on primary health care and community economic enhancement, as well as the opportunities it offers for health promotion for consumers and health career education for college students, can make a positive contribution toward reducing the factors that contribute to health disparities according to race. Among the factors cited in the State Health Plan are low socioeconomic status, inadequate access to and utilization of health care resources, cultural insensitivity and racial discrimination, lifestyle risk factors, and under-representation of minorities in the health professions.

> "While the gaps may have closed somewhat over the last few decades, blacks are still far less likely to receive the type and quality of care or to experience health outcomes as positive as whites."
>
> -Mississippi State Health Plan, 1996-97

According to the State Health Plan, "Reducing or eliminating such risk factors as smoking, inadequate nutrition, and substance abuse would decrease morbidity and mortality rates in the minority community. One or more of these factors contribute to all the conditions causing excess mortality among minority populations. Other factors include lack of early identification of disease, lack of access to health care, and poverty. Many factors contributing to excess deaths in the state's minority population are related to lifestyle. This situation emphasizes the need for health promotion and disease prevention within the minority community.

Access and Attitudes

Barriers to adequate health care for minorities include lack of access to the health care system, the cultural insensitivity of providers, the lack of health insurance services, officials who do not view chronic disease efforts targeted to minorities as a priority, and the attitude of health care providers (rudeness, domineering, or condescending).

Possible solutions include promoting health education for providers (especially minority providers), funding services and programs targeted to minorities, and evaluating the effectiveness of programs that minority groups need.

According to the State Health Plan for 1996-1997, "In addition, medical care is sensitive to health outcome, such as a correct diagnosis of what is or was wrong, rather than such measures of service as how well patients were treated and how or if the dignity of the patient was maintained. This factor may indicate that in addition to monitoring the effectiveness of medical care provided, it may be imperative to consider monitoring different patterns of care and the socio-behavioral aspects of health."

The Jackson Medical Mall has tremendous potential for a positive impact on the health of the population it serves. In order to resolve the historical pattern of chronic disabling diseases among minorities society must recognize that the health care system has evolved with little or no awareness of cultural differences and with little or no direct involvement from the minority community. Therefore, any mechanism developed must incorporate these five areas:

•Intervention plans must come from knowledge and consideration of the minority community.

•Multiple channels of influence must be used to bring about changes in health behavior, such as involvement of the community and appropriate health care providers.

•Intervention efforts should be incorporated/merged into existing social structures, practice patterns of service providers, and educational channels.

•Minority community participation should be encouraged at the earliest stages of planning and implementation.

•Improvements must be made to make health services more accessible to minorities.

These criteria from the State Health Plan are all addressed by the Jackson Medical Mall, creating in this facility tremendous potential for having a positive impact on improving the health status of the population it serves, primarily minority and low income.

Governance

A nonprofit 501-C-3 corporation, the Jackson Medical Mall Foundation is governed by a five- member Board of Directors with four seats currently filled. Board members include: Aaron Shirley, M.D., Chairman; Ted Woodrell, Vice Chairman, Hospital Administrator, University of Mississippi Medical Center; Reuben Anderson, Attorney-at-Law, Phelps Dunbar LLP and James Lyons, Ed. D., President, Jackson State University.

The Foundation by-laws state that all net proceeds from Foundation activities are to be distributed to the supporting organizations according to the following disbursement percentages: University of Mississippi Medical Center 35%, Jackson State University 15%, and

Tougaloo 15%. There is currently an unallocated supporting portion of 35%.

Jackson Medical Mall Foundation operations are managed by executive director Brad Chism, a Certified Economic Director (CED) with more than a decade of experience in economic and community development. A graduate of Millsaps College, Mr. Chism studied economics at Oxford University in Oxford, England, as a Rhodes Scholar before attending Deposit Guaranty National Bank's Credit Analysis School. He directed the Institute for Technology Development's Minority Business Enterprise Program and, most recently, served as Executive Director of the Natchez-Adams County Economic Development Authority.

The Foundation's Challenge

The Foundation can now turn its attention to the challenge of making it easier for health care and human service tenants to work together. "We hope to be a catalyst in the search for ways to improve health and social service care for clients of the Medical Mall tenants," says Brad Chism, the Medical Mall Foundation's Executive Director. "We will be looking for gaps in services that can be eliminated, overlaps in services that are burdens to taxpayers and can be reduced, and opportunities for synergies that result from all of these tenants being under one roof."



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ARENO, JOHN P., Hattiesburg. Born December 16, 1965, Lake Charles, LA. MD Louisiana State University School of Medicine, Shreveport, LA, 1991; internal medicine residency, same, 1991-94; pulmonary and critical care medicine, same, 1994-97; elected by South MS Medical Society.

BISHOP, ANDREW C., Jackson. Born Forest, MS, September 30, 1956; MD University of Mississippi School of Medicine, Jackson, MS, 1952; pediatric internship, same, 1982-83; psychiatry residency, same, 1983-86; elected by Central Medical Society.

BOWERS, DONN EMERSON, Greenville. Born Kansas, February 5, 1934; MD Louisiana Stat University School of Medicine, New Orleans, LA, 1959; internship, same, one year; internal medicine residency, Southern Baptist Hospital, New Orleans, 1960-61; internal medicine residency, Tulane and Southern Baptist Hospital, New Orleans, LA, with fellowship in rheumatology; anesthesiology residency, University of Texas at Galveston, Galveston, TX, 1983-85; elected by Delta Medical Society.

BROWNSTEIN, RICHARD E, Vicksburg. Born March 4, 1952; MD Jefferson Medical College of Medicine, Philadelphia, PA, 1976; general surgery & internal medicine residency, West Penn Hospital, Pittsburgh, PA, 1976-79; gastroenterology fellowship, Medical College of Georgia, Augusta, GA, 1981-83; elected by West MS Medical Society.

JAMES, MOORE CARTER, Biloxi. Born Alexandria, LA, August 26, 1959; MD Tulane Medical School of Medicine, New Orleans, LA, 1991; diagnostic radiology residency, St Joseph's Hospital and Medical Center, Phoenix, AZ, 1992-97; fellowship body imaging fellowship, same, 7/97 - 12/97; elected by Coast Counties Medical Society.

CLEMENTS, KELLY S., Hattiesburg. Born Baton Rouge, LA, July 20, 1966; MD Louisiana State University School of Medicine 1992; University of Texas Medical Branch, Galveston, TX, 1992-97; elected by South MS Medical Society.

COVIN, F. ALAN, Hattiesburg. Born Evergreen, AL, January 10, 1956; MD University of South Alabama School of Medicine, Mobile, AL, 1982; internal medicine residency, same 1982-85; cardiology fellowship, same, 1991-94; elected by South MS Medical Society.

DELOACH, MARK ALAN, Laurel. Born Laurel, MS, April 5, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1994; family medicine residency, University Medical Center, Jackson, MS, 1994-97; elected by South MS Medical Society.

DIXON, WILLIAM N., McComb. Born Jackson, MS, July 22, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1992; general surgery residency, University Medical Center, Jackson, MS, 1992-97; elected by South Central Medical Society.

FORRESTER, CARLOS, Pascagoula. Born Trinidad, West Indies, November 6, 1960; MD Howard University College of Medicine, Washington, DC, 1988; family practice residency, same, 1988-90; elected by Singing River Medical Society.

HUEY, ROGER, Greenwood. Born Indianola, MS, June 19, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1991; internal medicine, same, 1991-95; gastroenterology fellowship, same, 1995-97; elected by Delta Medical Society.

HUNT, NOEL K., Booneville. Born Union City, May 8, 1968; MD University of Mississippi School of Medicine, Jackson, MS, 1994; internal medicine residency, University of Tennessee Medical Center, Memphis, TN, 1994-97; elected by Northeast Medical Society.

KENNEY, ANN FOSTER, Tupelo. Born Cincinnati, OH, November 25, 1953; MD University of Toronto Medical School, Toronto/Ontario Canada, 1988; family practice residency, same, 1988-90; elected by Northeast Medical Society.

KERGOSIEN, CHARLES A., Bay St. Louis. Born Patrick AFB, FL, October 1, 1968; MD University of Mississippi School of Medicine, Jackson, MS, 1994; internal medicine residency, Emory University Medical Center, Atlanta, GA, 1994-97; elected by Coast Counties.

KINARD, HUGH CHRIS, Clarksdale. Born McAllen, TX, August 11, 1955; MD Louisiana State University Medical College, Shreveport, LA, 1985; internship, one year, Baptist Memorial Hospital; anesthesiology residency, University of Tennessee Medical Center , Memphis, TN, 1986-89; elected by Clarksdale & Six Counties Medical Society.

KIVLIGHN, JANE K., Hattiesburg. Born New Orleans, LA, November 23, 1965; MD University of Mississippi School of Medicine, 1991; one year internship, Abingohen Memorial Hospital, Pennsylvania; ophthalmology residency, Hahnemann University Hospital, Philadelphia, PA, 1992-95; pediatric ophthalmology, St Christopher's Hospital, Philadelphia, PA, 1995-96; elected by South MS Medical Society.

KUMI, KOFI O., Natchez. Born Ghana, October 10, 1961; MD University of Pennsylvania School of Medicine, Philadelphia, PA, 1992; ob-gyn residency, Baylor College of Medicine, Houston, TX, 1983-87; elected by Homochitto Valley Medical Society.

LATOUR, LYDIA F., Biloxi. Born New Orleans, LA, November 25, 1957; MD University of South Alabama Medical School, Mobile, AL, 1990; interned, one year, same; internal medicine residency, same, 1991-93; fellowship, hematology/medical oncology, same, 1993-97; elected by Singing River Medical Society.

LEE, ROBERT BLAIR, Jackson. Born Nashville, TN, August 12, 1956; MD University of Mississippi School of Medicine, Jackson, MS, 1984; surgery residency, Vanderbilt Medical Center, Nashville, TN, 1986-90; cardio thoracic surgery fellowship, MD Anderson Hospital, Houston, TX, 1990-91; elected by Central Medical Society.

MAYLARD, JOHN B., Pascagoula. Born Waco, TX, January 29, 1938; MD University of California Medical School, Los Angeles, CA, 1966; internal medicine residency, same, 1966-68 and 70-72; cardiology residency, same, 1972-74; elected by Singing River Medical Society.

McKEE, JOHN DAYMOND, Ocean Springs. Born Coral Gables, FL, July 31, 1961; MD University of Florida, Gainsville, FL, 1990; internal medicine residency, University of Florida, Jacksonville, FL, 1991-93; gastroenterology fellowship, same, 1993-95; advanced therapeutic endoscopy, Harvard Medical School, Boston, MA; elected by Coast Counties Medical Society.

MECCA, DANIEL J., Vicksburg. Born Syracuse, NY, March 14, 1967; MD State University of New York Health Science Center, Syracuse, New York, 1993; anesthesiology residency, University of South Florida College of Medicine, Tampa, FL, 1993-97; elected by West MS Medical Society.

METZGER, WILLIAM E., Southaven. Born Memphis, TN, September 22, 1931; MD University of Tennessee School of Medicine, Memphis, TN, 1954; internship, Confederate Memorial Medical Center, Shreveport, LA, 1954-55; elected by Desoto County Medical Society.

MYCHASKIW, GEORGE II, Greenville. Born Augusta, GA, June 16, 1962; MD University of Health Sciences, College of Osteopathic Medicine, Kansas City, MO, 1988; anesthesiology residency, Yale University School of Medicine, New Haven, CT, 1988-92; elected by Delta Medical Society.

NOFFSINGER, HANS, Booneville. Born Lexington, KY, November 14, 1955; MD University of Kentucky Medical School, Lexington, KY, 1995; interned one year and internal medicine residency, same, 1995-97; elected by Northeast MS Medical Society.

O'SULLIVAN, PATRICK J., Oxford. Born Dublin, Ireland, March 17, 1939; MD University College, Dublin, Ireland, 1964; internal medicine residency, St. Vincent Hospital, Dublin, Ireland, 1965-67; neurology residency, Strong Memorial Hospital, University of Rochester Medical Center, Rochester, New York, 1967-69 & 1971-72; elected by North MS Medical Society.

PHAN, HIEN V., Vicksburg. Born Cambodia, May 15, 1944; MD Hue Medical School, Vietnam, 1972; pediatric residency, St. Agnes Hospital, Baltimore, MD, 1979-80, Polyclinic Medical Center, Harrisburg, PA, 1980-82; pediatric anesthesiology fellowship, Akron Children Hospital, Akron, OH 1986-87; elected by West MS Medial Society.

RUSSELL, RICHARD L., Jackson. Born Oxford, MS, June 4, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1994; internal medicine residency, same, 1995-97; elected by Central Medical Society.

SECRET, BRADLEY N., Hattiesburg. Born Galveston, TX, September 23, 1961; MD University of Mississippi School of Medicine, Jackson, MS, 1987; surgery internship, University of Kentucky Medical Center, Lexington, KY, 1987-88; internal medicine residency, same, 1988-91; urology residency, University Medical Center, Jackson, MS, 1991-94; elected by South MS Medical Society.

SHAPIRO, STEVEN C., Hattiesburg. Born New York, New York, September 1, 1945; MD Tulane University School of Medicine, New Orleans, LA, 1970; pediatric residency, Mt. Sinai Hospital, New York, NY, 1971-73; pediatric dermatology fellowship, Stanford University Hospital, Palo Alto, CA 1975-76; elected by South MS Medical Society.

SIMMS, DENNIS C., Meridian. Born Lebanon, KY, August 28, 1959; MD University of Louisville Medical School, Louisville, KY, 1987; internal medicine internship, Portsmouth Naval Hospital, Portsmouth, VA, 1987-88; elected by East MS Medical Society.

SULLIVAN, WILLIAM B., Hattiesburg. Born Birmingham, AL, February 24, 1961; MD University of Alabama School of Medicine, Birmingham, AL, 1987; pediatric residency, University of Tennessee Medical Center, Memphis, TN, 1987-90; anesthesiology residency, same, 1990-91; allergy & clinical immunology residency, Louisiana State University of Medicine, Shreveport, LA, 1994-96; elected by South MS Medical Society.

VENTERS, STEVEN W., Vicksburg. Born St. Louis, MO, March 2, 1967; MD University of Tennessee School of Medicine, Memphis, TN, 1993; internal medicine & pediatric residency, St. Louis University Hospital, St. Louis, MO, 1993-97; elected by West MS Medical Society.

VERMA, SATISH C., Greenville. Born New Delhi, India, August 27, 1968; MD Maulana Azad Medical College, New Delhi, India, 1991; pediatric residency, Rush Childrens Hospital, Chicago, IL, 1993-96; elected by Delta Medical Society.

VOULTERS, LEE, Vicksburg. Born London, England, May 7, 1951; MD Royal Free Hospital, School of Medicine, London, England, 1978; internship, one year, same; neurology residency, University Western Ontario. Canada, 1981-84; neurology residency, College of Physicians & Surgeons, Columbia University, New York, NY, 1984-86; elected by West MS Medical Society.

WALKER, RONALD RAYMOND, Water Valley. Born New York City, NY, October 23, 1952; MD University of California School of Medicine, San Diego, CA, 1982, medicine residency, Kaiser Foundation Hospital, 1982-84; elected by Northeast MS Medical Society.

WALKER, SUE D., Jackson. Born Port Arthur, TX, May 3, 1952; MD University of Mississippi School of Medicine, Jackson, MS, 1990; pathology residency, University Medical Center, Jackson, MS, 1990-95; dermatopathology fellowship, University of Texas Southwestern Medical School, Dallas, TX, 1998-99; elected by Central Medical Society.

WILLIS, ALPHONSO, Hattiesburg. Born Hattiesburg, MS, June 16, 1953; MD Harvard Medical School, Boston, MA, 1977; internal medicine residency, Letterman Army Medical Center, San Francisco, CA, 1977-80; medical oncology fellowship, same, 1980-82; elected by South MS Medical Society.

WING, DALE L., Pontotoc. Born Clarksdale, MS, July 17, 1961; MD University of Mississippi School of Medicine, Jackson, MS, 1987; family medicine residency, US Naval Hospital, Charleston, SC, 1987-90; elected by Northeast MS Medical Society.

WINN, LAUREN M., West Point. Born Summit, NJ, May 13, 1961; MD Louisiana State University School of Medicine, New Orleans, LA, 1991; ob-gyn internship & residency, University of Rochester/ Strong Memorial Hospital, Rochester, NY, 1991-95; elected by Prairie Medical Society.

YERGER, BUFORD L., JR., Jackson. Born Jackson, MS, December 8, 1934; MD University of Mississippi School of Medicine, Jackson, MS, 1960; internal medicine residency, same, 1960-63 and orthopaedic surgery residency, same; elected by Central Medical Society.

DEATHS

ANDY, ORLANDO J., Jackson. Born Connecticut January 21, 1920; MD University of Rochester Medical School, Rochester, NY, 1945; interned one year, St. Francis Hospital, Hartford, CT, and one year Baptist Memorial Hospital, Memphis, TN; resident in surgery, Alexandria VA Hospital, 1946-48; fellowship, neuropsychiatry institute 1949; neuro surgery residency Johns Hopkins University, Baltimore, MD; died November 6, 1997, age 78.

O'FERRALL, R. CARTER, Jackson. Born Enterprise, MS, April 27, 1901; MD University of Pennsylvania School of Medicine, Philadelphia, PA, 1927; interned, Touro Infirmary, New Orleans, LA, 1927-29; died December 5, 1997, age 96.

SCHMIDT, HARRY J., Biloxi. Born Ocean Springs, MS, December 28, 1905; MD Tulane University School of Medicine, New Orleans, LA, 1932; interned one year, Mercy Hospital, New Orleans, LA; died August 31, 1997, age 91.

SNOW, RICHARD C., Jackson. Born Denver, CO, August 6, 1918; MD Medical College of Virginia, Richmond, VA, 1952; interned one year, Scott & White Hospital, Temple, TX; anesthesiology residency, same, 1953-54 and Charity Hospital, New Orleans, LA, 1954-55; died November 11, 1997, age 79.

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Alan E. Freeland, M.D., Professor in the Department of Orthopaedic Surgery and Rehabilitation at the University of Mississippi Medical Center (UMC) in Jackson, Mississippi, was named the national Clinician/Teacher of the Year for 1997 by the American Association for Hand Surgery at their 28th Annual Meeting in Phoenix, Arizona, held January 7-10, 1998. Dr. Freeland currently serves as treasurer of the organization.

Charles Ozborn, M.D. spoke to the Faith Cancer and Cardiac support group in the Webster Health Services, Incorporated cafeteria. The topic was "What You Need to Know about Lymphoma."

Steven C. Brandon, M.D. of Starkville has been named a Diplomate of the American Board of Family Practice (ABFP), the certifying entity of the family practice specialty. Dr. Brandon, a family physician, earned diplomate status by passing the ABFP's certification examination, an intensive written test of the physician's abilities in pediatrics, internal medicine, surgery, obstetrics, gynecology, psychiatry, prevention and other aspects of family practice. ABFP Diplomates must continue to demonstrate their competence in the specialty by taking recertification exams every six years. Family practice was recognized in 1969 as a medical specialty by the American Medical Association and the American Board of Medical Specialties, and it was the first specialty to require its Diplomates to take recertification exams at regular intervals.

John H. Eichhorn, M.D. of Brandon, professor and chair of anesthesiology at the University of Mississippi Medical Center, gave a refresher course lecture on "Risk Management in Anesthesia" at the annual meeting of the American Society of Anesthesiologists in San Diego, California. He also chaired the ASA Committee on Standards Care.

Steven E. Zachow, M.D. has been named chief-of-staff-elect at Methodist Medical Center in Jackson. He is a radiation oncologist and director of the hospital's department of radiation oncology. He received his medical degree from the University of Alabama School of Medicine and did his residency at the Medical College of Virginia.

Ralph E. Dunn, M.D. has retired from Jackson Anesthesia Associates, PA.

Randall S. Hines, M.D., of Jackson, assistant professor of ob-gyn, recently received the Berlex Foundation Scholar Award for $60,000 for his research in implantation, how a developing embryo attaches to and grows in the uterus. The University of Mississippi Medical Center physician is one of two scientists in the country to receive the prestigious award for his promising and innovative research in the field of reproductive medicine. His research proposal entitled "Nidation Signaling: Trophoblast Regulation of Endometrial Gene Expression," has the potential for many scientific and clinical applications. Implantation involves alterations of the immune system, cell growth, limits to the invasive properties of cells, and has implications for infertility, pregnancy loss and abnormalities of placental development, such as preeclampsia. Hines' work focuses on what causes implantation to fail. Hines' research was selected for the grant primarily because of his ingenious research method. He grows endometrial tissue, the mucous membrane comprising the inner layer of the uterine wall, and trophoblast, tissue representing the developing pregnancy, in petri dishes in the lab. Hines then uses a technique called differential display, developed by Harvard scientists Dr. Peng Liang and Dr. Arthur Pardee, which allows him to compare gene expression, the conversion of DNA to RNA, in two similar tissues. According to Hines, "Basically, differential display is a way of starting with a clean slate rather than beginning with a preconceived idea about the role of a specific gene, this method reveals all the genes that are 'turned on' when the trophoblast interacts with the endometrium. In this way, we hope to see which genes are important in the cross talk between the implanting embryo and the endometrium within the uterus." The Berlex Foundation, a non-profit organization established in 1986 to support education and research in reproductive medicine, is administered by a board of trustees comprised of America's leading ob-gyn researchers, educators and clinicians.

C. Ralph Daniel, III, M.D., has given numerous talks on Fungi and Nail Disorders. Over the past year he has given talks in locations such as Sydney, Taiwan, New York, Los Angeles, Washington, D.C.; Florida and San Francisco.

Mississippi Institutions and Organizations Accredited as Providers of Intrastate Continuing Medical Education

The following medical institutions or organizations have been accredited as providers of CME by the MSMA's Council on Medical Education. Accreditation is awarded in accordance with the ACCME's/*MSMA's* ***"Essentials for Accreditation of Sponsors of Continuing Medical Education" and "Standards for Commercial Support of Continuing Medical Education."*** Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing or calling the Director or Coordinator of Continuing Medical Education at the individual institution or organization.

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150 Reynoir Street
Biloxi, MS 39530

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3531 East Lakeland Drive
Jackson, MS 39296

Council on Scientific Assembly
MS State Medical Association
735 Riverside Drive
Jackson, MS 39202

Delta Regional Medical Center
1400 East Union Street
Greenville, MS 38704

Forrest General Hospital
Mamie Street & Highway 49 South
Hattiesburg, MS 39404

Greenwood Leflore Hospital
1401 River Road
Greenwood, MS 38930

Grenada Lake Medical Center
960 Avent Drive
Grenada, MS 38901

Jeff Anderson Regional Medical Center
2124 14th Street
Meridian, MS 39301

King's Daughters Hospital
Highway 51 North
Brookhaven, MS 39601

King's Daughters Hospital
300 South Washington Street
Greenville, MS 38702

Medical Assurance Company of Mississippi
735 Riverside Drive, Suite 301
Jackson, MS 39202

Memorial Hospital at Gulfport
4500 13th Street
Gulfport, MS 39502

Methodist Medical Center
1850 Chadwick Drive
Jackson, MS 39204

MS Baptist Medical Center
1225 North State Street
Jackson, MS 39202

MS State Department of Health/
MS Association of Public Health Physicians
Post Office Box 1700
Jackson, MS 39215

Natchez Regional Medical Center
54 Sergeant S. Prentiss Drive
Natchez, MS 39121

North MS Medical Center
830 South Gloster Street
Tupelo, MS 38801

Northwest MS Regional Medical Center
1970 Hospital Drive
Clarksdale, MS 38614

Rush Foundation Hospital
1314 19th Avenue
Meridian, MS 39301

Singing River Hospital
2809 Denny Avenue
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Hattiesburg, MS 39404

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When Your Patient Asks: *"Doctor, I Read There Have Been Serious Pap Smear Errors. Shouldn't I Get One of Those New Computer Pap Smears?"*

Richard C. Boronow, M.D.
James R. Cavett III, M.D.

Preface

"She was bright, health-conscious, and she believed her doctors. It couldn't be serious – the tests said so." Source: "What managed care did to Karin Smith," Reader's Digest, July 1997 [1]

"The chance of missing an abnormality on a Pap smear ranges from 5-50%, often because of human error. Now, several new Food and Drug Administration-approved computerized devices – AutoPap and Papnet – can rescreen Pap smears, picking up warning signs that might be missed by lab technicians. Another new device is ThinPrep, which makes cervical-cell samples easier for labs to evaluate." Source: "Health Check, Good Housekeeping, August, 1997 [2]

Introduction

The Pap smear – the analysis of cells obtained from the uterine cervix – is arguably the most cost-effective and beneficial cancer screening test ever devised. This was widely appreciated in recent decades and, indeed, the U.S. Postal Service, in 1980, struck a commemorative stamp in honor of Dr. George Papanicolaou, the developer of the test.

The Pap test, like every test we do in medical practice, is not without the potential for error. Errors have occurred. Large lawsuits and glaring errors have been highlighted in the press. These occasional cases have been magnified out of focus, blurring the larger picture. Today, the validity of the Pap smear is besieged not only by the media and plaintiff attorneys, but by certain commercial interests, anxious to market their alternative to the traditional Pap test. All of this has planted seeds of uncertainty and there is a wide-spread crisis of confidence among our patients, and patients nationwide. This is a tragedy, and should the current contentious environment continue to flourish, it could indeed lead to the death of the Pap smear. [3]

This report is prepared to summarize, as succinctly as possible, not only the specifics of the newly emerging technologies, but also to review for the practicing physician, pertinent clinical background and practicalities that relate to the current controversy about cervical cytology.

The evolution of cervical cytology and the natural history of cervical cancer

In order to develop a better appreciation of what is meant by "the chance of missing an abnormality" one must appreciate the *spectrum* of abnormalities. And to that end, it seems appropriate that we review some important facts about cervical cancer and cervical cytology.

Papanicolaou was studying endocrine changes in the female genital tract when, in 1928, he made the observation of cells that came from a cervical cancer. He pursued his work and the first major clinical paper was published in 1941. [4] Our current understanding of the evolution of cervical cancer did not exist at that time, and much of the discussion focused not only on cells derived from cervical cancer but also the possibility that cells from endometrial cancer, ovarian cancer, or even tubal cancer might be found! The first Pap smear classification was published in 1954 (Table 1A). [5]

Diligent work by distinguished pathologists through the 1940's, 1950's, and 1960's began to paint a picture of cervical cancer as a continuum, progressing from normal squamous epithelium to mild dysplasia, then

moderate dysplasia, then severe dysplasia, then carcinoma in situ, and finally invasive cancer (Table 2A). This emerging continuum was roughly transposed to an interpretive modification, a practical working modification, if you will, of the original Pap smear classification (Table 1B). Indeed, Mississippian Frank Foote was among the early investigators to document cytologic diagnosis of preinvasive cancer. [6, 7, 8]

Then, in 1969, Ralph Richart and Bruce Barron [9] integrated this concept of a continuum of progressive neoplastic change and coined the term "cervical intraepithelial neoplasia" (CIN). The evolution of this terminology is displayed in Table 2B. In more recent years, since many pathologists felt that the clinical implications of severe dysplasia and carcinoma in situ were similar, and since there was often difficulty distinguishing the two histologically, they were grouped as CIN III (Table 2B). [10]

As clinicians became comfortable with this concept of a clinical continuum, it was appreciated that the progression from normal to invasive cancer was *ordinarily slow*, progressing over a 5 to 20 year range. While this is the general rule, there are exceptions, where the evolution appears to be much more rapid.

And another modification of our earlier clinical thinking has been the appreciation that *not all* mild dysplasias progress. Indeed, as Richart and Wright recently observed "the natural history of low grade CIN is controversial . . . nonetheless a *consensus* has been reached that low grade CIN lesions have a *high spontaneous remission rate* and are *unlikely to progress* to invasive cancer, and that the time required to progress to cancer is sufficiently long that the *risk of an invasive cancer* occurring during a short period of follow-up *is negligible* (our italics). [11]

These considerations, coupled with the relative lack of specificity of the Pap smear classification as it was being employed, prompted the convening of a committee by the National Institutes of Health chaired by Johns Hopkins pathologist, Robert Kurman. This committee developed the classification system currently in use and known as The Bethesda System (TBS) (Table 1C). [12]

This acknowledges the prevailing view at present that low grade lesions will sometimes heal themselves and regress, whereas the high grade lesions are more likely to persist and progress with time if not treated. A strength of The Bethesda System is its emphasis on specimen adequacy. The screening technician is requested to indicate whether the specimen is adequate or not, whether it is limited or unsatisfactory due to the fact that no endocervical cells may be seen, too few cells are seen, or obscuring

Table 1A

Original Pap Classification

I.	Absence of atypical/abnormal cells
II.	Atypical cells but no evidence of malignancy
III.	Suggestive of malignancy
IV.	Strongly suggestive of malignancy
V.	Conclusive for malignancy

Table 1B

Modified Pap Classification

I.	Normal
II.	Non-neoplastic atypia
III.	Dysplasia
IV.	Cancer in situ
V.	Invasive cancer

Table 1C

The Bethesda System (TBS)

Squamous cell abnormalities

Atypical squamous cells of uncertain significance – ASCUS

Low grade squamous intraepithelial lesion - LGSIL
- •HPV changes (koilocytosis, koilocytotic atypia, condylomatous atypia)
- •Mild dysplasia (CIN 1)

High grade squamous intraepithelial lesion - HGSIL
- •Moderate dysplasia (CIN 2)
- •Severe dysplasia (CIN 3)
- •Carcinoma in situ (CIN 3)

Squamous cell cancer

Glandular cell abnormalities

Table 2A

Evolution of Cervical Cancer

- ➤ Normal
- ➤ Mild dysplasia
- ➤ Moderate dysplasia
- ➤ Severe dysplasia
- ➤ Carcinoma in situ
- ➤ Invasive cancer

Table 2B

Cervical Intraepithelial Neoplasia (CIN)

CIN 1	Mild dysplasia
CIN 2	Moderate dysplasia
CIN 3	Severe dysplasia
CIS	Carcinoma in situ
- -	
CIN 1	Mild dysplasia
CIN 2	Moderate dysplasia
CIN 3	Severe dysplasia and CIS

Table 3

Summary of Cytologic Factors in False-Negative Diagnosis

Few cells
- <100 abnormal cells

Small cells
- Difficult to spot ("no-see-ums")

Bland cells
- Difficult to interpret
  - Differential diagnosis: immature metaplasia, histiocytes

Hyperchromatic crowded groups (HCGs)
- Atrophy, endometrium, etc. vs carcinoma

Certain tumor types
- Adenocarcinoma, lymphoma, sarcoma, etc.

Obscuration of smear
- Excess exudate, blood, air drying, degeneration, etc.

Inadequate patient information

DeMay with permission [13]

inflammation, obscuring blood, air drying artifact or other features. A specimen deemed "inadequate" or "unsatisfactory" may be an annoyance to the clinician, but can be a protection not only to the pathologist, but the clinician and the patient as well.

One of the most controversial aspects of The Bethesda System is the introduction of the category "atypical squamous cells of undetermined significance" (ASCUS) and the glandular counterpart, termed "atypical glandular cells of undetermined significance" (AGUS). The pathologist or screener is asked to convey their bias that the atypia is either of neoplastic or non-neoplastic origin. Reproducibly objective criteria for these designations are felt by many to be elusive, and critics have suggested that these categories may be a reinvention of the original Papanicolaou Class II category. [3]

But the take-home message, the practicality of these emerging clinical correlations, is that cervical cancer generally evolves very slowly, and that regular annual cervical cytology will allow identification of precursor lesions in ample time for appropriate treatment and eradication. Numerous population-based studies have documented this benefit. And clearly, the incidence of cervical cancer has declined impressively. The mortality rate of cervical cancer in the United States was 30 deaths per 100,000 U.S. women in 1930 and the death rate in 1997 is 2.6 per 100,000 American women according to American Cancer Society statistics.

The contentious environment

The current storm rages over the issue of "false negative" smears.

"False negative" smears in patients with invasive cervical cancer, or pre-invasive lesions, can be divided into sampling and laboratory errors. At least half of false negative Pap smear results are due to sampling problems – abnormal cells are *not* present on the smear when rescreened. In some of the cases, abnormal cells may be obtained by the sampling device but are obscured on the smear because of blood and/or fixation. Laboratory false negative results may be a result of screening errors, interpretive errors, or a paucity of well-visualized abnormal cells. When one considers that there may be as many as 50,000 to 300,000 cells on an individual slide, an occasional abnormal cell, and particularly, the occasional subtly abnormal cell could easily be overlooked in the routine screening process. Most cytopathologists agree with DeMay [13] that there must be at least 100 abnormal cells for a reasonable chance of recognition (Table 3).

The Pap test is a *screening* test. Yet to a large

extent, the public views it as a *diagnostic* cancer test with essentially 100% accuracy. Each of us must deal with the education of our patients very diligently and we will return to this in a later section.

Plaintiff attorneys have their claims. Pathologists and cytopathologists have their counter-claims. Issues of off-site screening (such as a technician taking slides home and reviewing them in her kitchen or home office area), over-productivity, and a technique of payment by the slide, all are practices not approved by College of American Pathologists' guidelines, and Federal guidelines, as enunciated in CLIA-88. Yet plaintiff attorneys have found examples of violations of these guidelines, and some laboratories have also been criticized for the failure to reject smears as "unsatisfactory" or "inadequate."

Cytopathologists have three major concerns. The first is a flawed appreciation of the screening nature of the Pap smear (referenced above). This involves the subjective as well as objective interpretive nature of cytodiagnosis, searching a slide that may contain from 50,000 to 300,000 cells. Their second concern relates to the continued pressure to reduce costs. The fee for the Pap smear was originally set artificially low, purposely low, so as to be readily affordable and widely available. Now cytopathologists are facing rising costs that include mandatory rescreening, increased insurance, and inflation coupled by decreasing revenue through Medicare, Medicaid, managed care, and contractual agreements. And finally, there is a concern about the mixed blessing of certain types of automation. This will be discussed in the next section.

The commercial solution

The FDA has, to date, approved two automated devices for rescreening and quality control; they have not yet been approved for routine screening. The two approved devices are the Papnet and AutoPap 300.

The Papnet system rescreens conventionally prepared smears that were previously judged negative. This is done off-site on an automated computerized microscope which utilizes algorithms and neural networks and selects 128 optical images of cells, cell groups, judged to be most abnormal and are saved on a digital tape for subsequent review.

The AutoPap 300 is a non-interactive system which uses algorithm classifiers to provide a slide evaluation score on each slide. Slides with scores above a determined threshold are manually rescreened; the technology aims to cluster the abnormal cases above that threshold.

Both of these technologies have documented fewer false negatives; but also there are more false positives.

The ThinPrep 2000 is the only FDA-approved monolayer technology to date. A "broom" type of collective device must be used. The sampling device is placed in a vial of fixative rather than being smeared onto a slide, and monolayer preparations are prepared within the laboratory. The system passes the cell suspension through a polycarbonate filter to a specified density and then touches the filter to a slide.

Each of these technologies have merit, but obviously add substantially to cost.

The problem in fact

The Good Housekeeping article made reference to the chance of missing an abnormality on a Pap smear ranging from 5 to 50%. Missing an invasive cancer is serious. Missing a high-grade lesion could be serious, especially if the patient does not return for Pap smears on a regular annual basis. Missing a low grade lesion or an ASCUS or AGUS call will not likely be serious either, provided the patient avails herself of regular cytology. So, the practicality of a statistic that reports "abnormalities missed" really is only significant if one breaks this figure down into clinically significant errors and clinically insignificant errors, coupled with the patient's compliance with regular exams, that is, her own sense of personal responsibility. Will the patient be harmed or will the patient not be harmed?

Also essential in the equation is the necessity that the laboratory one uses is one of high quality, and one that follows the guidelines for laboratory accreditation of the College of American Pathologists and the American Society of Cytopathology and the regulations enacted in CLIA-88 (Clinical Laboratory Improvement Amendments of 1988). The practitioner protects himself and his patients by making this inquiry.

The reality of Pap smear screening is that (1) a zero standard is impossible, (2) there is an irreducible 5-10% false negative rate (of cancer or squamous intraepithelial lesions in previous screened smears). This would represent an average in good laboratories. [14, 15] If one includes missing ASCUS/AGUS, then the irreducible false negative rate would probably move up to 10-20% range. But importantly, a major error is rare. And a reminder once again – clinician failure is very real. This is discussed further in Practical Recommendations (see below).

But what our patients want to know is *"What is the risk of an error when my Pap smear is examined?"* DeMay [13] estimates that the major error risk in the quality lab is only about 1 in 1000 or 0.1%. This, coupled

with our recommendation of *regular annual exams* should be reassuring to most of our patients.

With regard to the current Pap smear dilemma, we believe the following statement very accurately reflects the situation: "We need to keep in mind that virtually everything we do to the Pap smear takes time and costs money. So when the 'cytobureaucracy' proposes more rules and regulations, or when commercial vendors propose their whiz-bang computers, or when lawyers prod us into practicing defensive medicine, we should be aware that all of these things add to the expense. There is a real danger that we will make the Pap smear so good that no one will be able to afford it. A $100.00 Pap smear may soon become a reality when one includes the cost of thin-layer preparation, computer rescreening, compliance with all applicable government regulations, and malpractice insurance. Loss of the inexpensive, widely available Pap smear will undoubtedly lead to increased cervical carcinoma." [13]

The Mississippi challenge

Figures 1, 2, and 3 are reproduced with permission from Mississippi State Department of Public Health data. [16] While Figure 1 reflects a downward trend in the incidence of cervical cancer, Figure 2 reflects very little improvement in overall mortality rates over the last 15 years and Figure 3 is shocking when compared to overall U.S. data. As stated earlier, the current mortality of cervical cancer is 2.6 American women per 100,000. The rates in the majority of counties in Mississippi, as seen in Figure 3, exceed this rate.

The tragic truth is that the majority of women with cervical cancer have *never* had a single Pap smear. This is the "silent majority," the *unscreened* women that need to be reached. And the majority of women who have developed cervical cancer, but who have had a Pap smear, have not had one for the last three to five years. This remains a major public health challenge.

Practical recommendations

Obtaining the Pap smear

It may be of value to reemphasize some practical points about obtaining the Pap smear. Good light and good visualization are necessary. The cervix and vagina must not have been previously exposed to glove powder or lubricant. The tip of the applicator must get into the cervical os so as to obtain endocervical cells, and the circumferential scrape of the cervix should be thorough. The patient should actually experience at least some slight degree of discomfort if one is to assume that the scrape was firm enough to get a generous sample. And finally, the secretions must be plated on the slide promptly and thinned out so as to obtain a good monolayer, and avoid the "glob" effect. And it must be fixed promptly either with a hand-held spray solution or dropped quickly into a solution of ethyl-alcohol.

Clinical assessment

If the cervix "looks bad" and the Pap smear is negative, resist the temptation to ask the pathologist to review the slide. Obtain colposcopic and/or biopsy evaluation. Papanicolaou's admonition in earlier writings stressed the need for careful clinical assessment. An "angry-looking cervix," or one with "chronic erosion" with a negative Pap smear are indications for adequate tissue evaluation, not cryotherapy! Post-coital bleeding and abnormal uterine bleeding all fall into the same category.

And it is worthwhile stressing once again that cervical cytology is rarely of value in assessing endometrial pathology that may be causing menopausal or post menopausal bleeding.

Recommended education of patients

We must stress to our patients that the Pap test is a screening, not a diagnostic, study. We must reassure them that the false negative rate for a serious lesion is definable, yet low, and if one couples knowledge of the slow evolution of cervical cancer with regular annual Pap smears, a serious miss would be most unlikely. Finally, we must stress to them that the Pap smear is primarily a test performed routinely on *asymptomatic* women and that abnormal symptoms or findings must be followed by appropriate evaluative studies.

Conclusion

Far more women develop cervical cancer because of the failure to get regular annual Pap smears than because of errors in cyto-diagnosis. If the public wants the $100–$150 Pap smear, we can make it available. But the public is accustomed to the current cost structure, and it seems to us that the public and private sectors are best served if the low cost and more universally available current test is retained in standard practice.

Our obligation to our patients is (1) to take and plate the smear with great care, (2) to know that the laboratory we use complies with all contemporary regulations and is accredited, (3) to be sure that our patients understand the screening rather than diagnostic nature of the Pap test, (4) that they understand the necessity that the test be repeated annually, (5) that we ourselves use the smear as a screen in *asymptomatic* women, and use a variety of evaluative

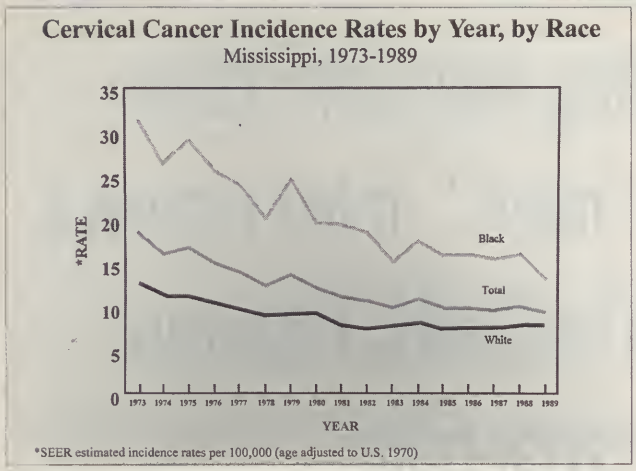


Figure 1. Cervical cancer incidence. Penman with permission (16).

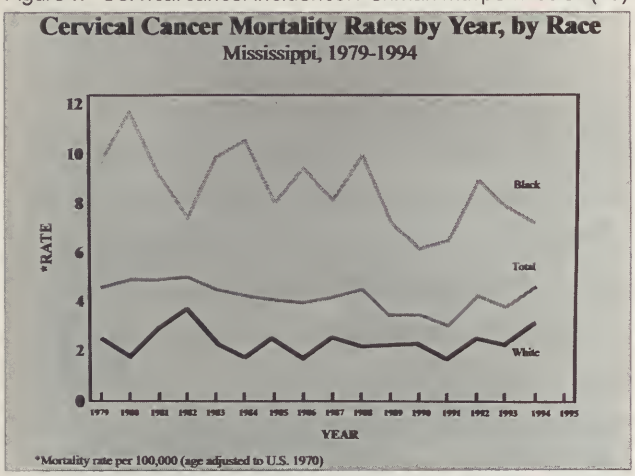


Figure 2. Cervical cancer mortality. Penman with permission (16).

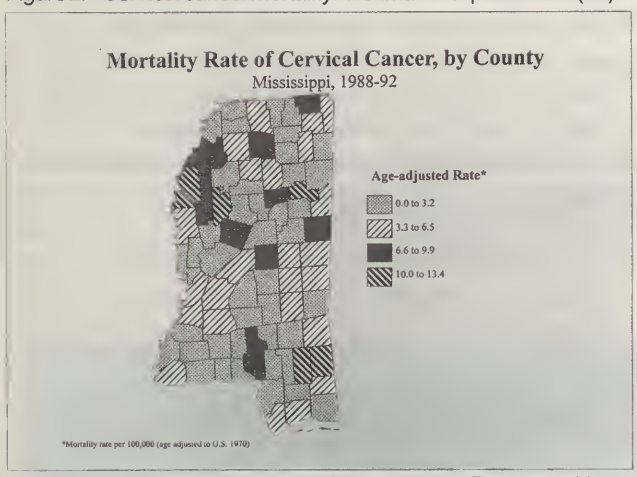


Figure 3. Cervical cancer mortality by county. Penman with permission (16).

techniques or referral for histological clarification of *symptomatic* women, and (6) that we, additionally, use critical clinical judgement if there is discordance between a negative Pap smear and positive clinical findings and/or symptoms.

If all of these steps are followed, significant "misses" will be rare. Cyto-diagnostic precision is not only a function of the laboratory, but also a function of the diligence of the clinician and the compliance of our patients.

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Laryngeal Nerve Monitoring During Thyroidectomy

C. Ron Cannon, M.D.

Damage to the laryngeal nerves during thyroid surgery remains a source of significant morbidity in patients undergoing thyroidectomy.[1, 2] Damage to the recurrent laryngeal nerve with subsequent paralysis ranges from 0.3 percent to 13 percent.[3] Damage to the external branch of the superior laryngeal nerve, which is important to singers, can also occur during thyroidectomy and is often overlooked. (Fig.1) There has long been interest in monitoring the laryngeal muscles intraoperatively during thyroidectomy. The simplest method involves palpating the laryngeal muscles while stimulating the laryngeal nerve.[4] A more invasive method consists of inserting small needles into the vocal muscles and monitoring the response while stimulating the recurrent laryngeal nerve.[5] Others have fabricated a double balloon endotracheal tube, positioning the proximal balloon between the vocal cords while monitoring pressure changes during stimulation.[6] Monitoring of electromyographic activity intraoperatively has been developed for several cranial nerves.[7] For example, monitoring of the facial nerve during parotid surgery or acoustic neuroma removal is now routinely employed.

The purpose of this article is to communicate and detail the author's experience using a more recent non-invasive method of monitoring the recurrent laryngeal nerve during thyroid surgery.

Technique: Proper management of a patient undergoing thyroid surgery involves preoperative evaluation of the vocal cord function. This is carried out in the office prior to surgery, usually by indirect laryngoscopy, using a mirror to visualize the vocal cords. Occasionally a fiberoptic examination is needed to assess vocal cord function. If vocal cord paralysis is found preoperatively and it should be evaluated prior to any surgery.

At the time of surgery the patient's neck is hyperextended on a shoulder roll. A non-paralyzing anesthetic agent is used so that function of the recurrent laryngeal nerve can be monitored during surgery. Dissection in the recurrent laryngeal nerve triangle bounded medially by the trachea, superiorly by the thyroid lobe, and laterally by the carotid sheath is of utmost importance in determining the location of the recurrent laryngeal nerve. At the time of intubation a special endotracheal tube is utilized. This tube has bipolar stainless steel contact electrodes on each side of the endotracheal tube. The endotracheal tube is positioned and taped into place so that one set of electrodes contacts one vocal cord while the other set of electrodes contact the other vocal cord. Movement of the vocal cords then allows an EMG reading (Figure 2). Ground electrodes and a stimulating probe then complete the circuit and allow use of the nerve integrity monitor (Figure 3). The monitor used in the

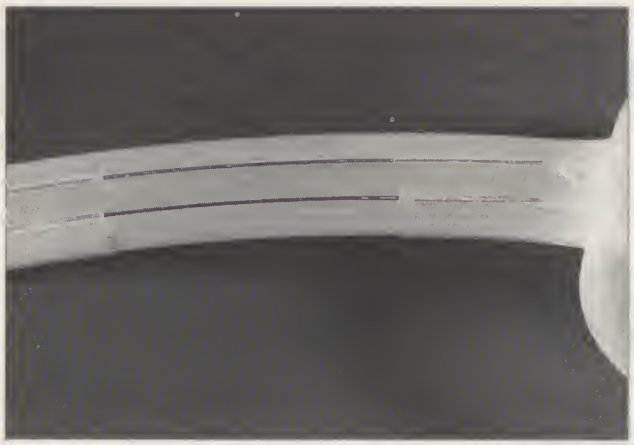


Figure 1: Anatomy of the laryngeal nerves. The external branch of the superior laryngeal nerve innervates the cricothyroid muscle. This has the effect of tensing the vocal cords and is important to singers as this allows them to "hit the high notes." The right recurrent laryngeal nerve, most commonly injured during thyroidectomy loops around the subclavian artery. The left recurrent laryngeal nerve loops around the arch of the aorta.

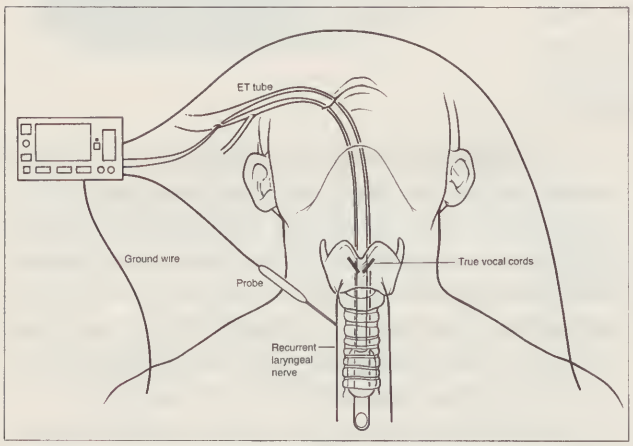


Figure 2: Endotracheal tube for use in laryngeal nerve monitoring. Note the exposed electrodes, one for each side of the larynx.

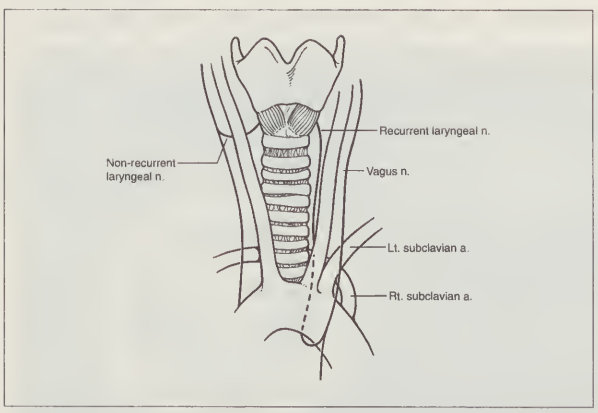


Figure 3: Schematic illustration of recurrent laryngeal nerve monitoring using the nerve integrity monitor.

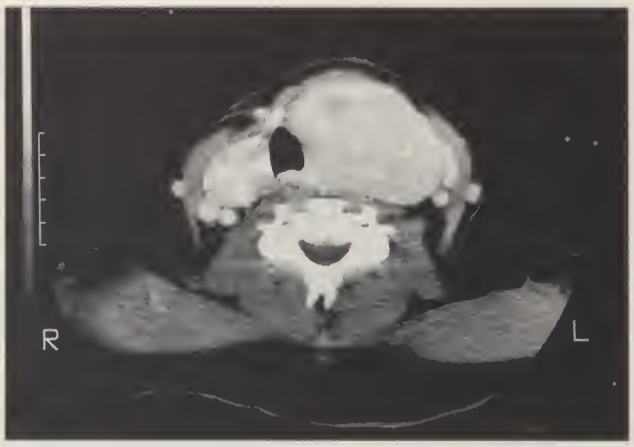


Figure 4: Operative positioning of a patient undergoing thyroidectomy. The nerve integrity monitor is placed in such a way as to allow easy visual access for the surgeon to see the monitor.

study was a NIM-2 monitor supplied by Xomed-Treace Company of Jacksonville, FL. The monitor allows both auditory and visual readout to the surgeon. The monitor is placed so that it can easily be seen by the surgeon during the procedure (Figure 4).

During the procedure various stimuli, including traction, spontaneous movement of the vocal cords, or direct stimulation of the recurrent laryngeal nerves can be monitored. The stimulus intensity from the stimulator probe can also be varied as can the threshold for response by the electrodes within the endotracheal tube.

Case Studies: Several case studies are included to demonstrate the usefulness of the NIM-2 monitor during thyroid surgery.

Case 1: A 32 year old white male, underwent surgery for a cold nodule which had been unresponsive to a course of thyroid suppression for what was ultimately found to be a well differentiated follicular carcinoma of the thyroid gland. At the time of surgery the right recurrent laryngeal nerve triangle was empty in that the recurrent laryngeal nerve did not course through this area. Further dissection indicated that the patient had a nonrecurrent laryngeal nerve. The nerve arose directly from the vagus and passed beneath the carotid artery, and into the larynx. The function and definite identification of this aberrant laryngeal nerve was verified with the nerve integrity monitor. Postoperatively the patient was found to have normal vocal cord function.

Case 2: A 34 year old black female, underwent a total thyroidectomy for a large nodular goiter causing

airway compression. The right lobe of the thyroid gland measured nine centimeters x five centimeters. After removal of the right lobe of the thyroid gland the nerve integrity monitor was used to stimulate the recurrent laryngeal nerve. Her thresholds were not elevated, indicating normal recurrent laryngeal nerve function on this side. Subsequently, the left lobe of the thyroid gland, measuring approximately 11 centimeters x five centimeters was removed. The nerve integrity monitor was useful in this case in demonstrating normal recurrent laryngeal nerve function prior to undertaking a total thyroidectomy. Also, it allowed the surgeon to note at the end of the procedure that both laryngeal nerves functioned normally and that airway obstruction due to the bilateral vocal cord paralysis would not ensue.

Comment: The concept of electromyographic monitoring of the recurrent laryngeal nerve is straightforward. Stimulation of the recurrent laryngeal nerve and subsequent movement of the vocal cords is detected by the electrodes implanted in the endotracheal tube which subsequently is verified both with auditory and visual monitoring on the monitor.

This technique is non-invasive and requires only proper placement of the endotracheal tube. Other methods of laryngeal monitoring in the past have utilized needles or hook electrodes which had to be placed in specific areas within the larynx. This was not only time consuming but also fraught with the possibility of causing a postoperative edema or long term muscle damage within the larynx. The dual system of both auditory and visual feedback for the surgeon is valuable. The visual readout on the screen of the monitor provides an objective assessment of the level of function of the vocal cords.

This technique of recurrent laryngeal nerve monitoring during thyroidectomy is a useful adjunct but does not take the place of full knowledge of the anatomy of the recurrent laryngeal nerve as it courses beneath the thyroid gland, nor does it replace meticulous surgical technique in identifying and preserving the integrity of this nerve. It is most useful, however, to verify that a structure is indeed the recurrent laryngeal nerve and also provides an objective assessment of its function. The need for an increased stimulus or a decreased response threshold by the recurrent laryngeal nerve may indicate decreased function and subsequent paralysis. In this event, the patient may be counseled more effectively postoperatively regarding the possibility of long term vocal cord paralysis.

Another useful function of the nerve integrity monitor is to prevent undue retraction on the recurrent laryngeal nerve during the surgical dissection. If undue retraction is placed on the recurrent laryngeal nerve this noxious stimulus can be changed by replacing or moving the retractors within the surgical field or altering the angle of dissection on the recurrent laryngeal nerve.

Other potential uses for this nerve integrity monitor in neck surgery include patients undergoing anterior cervical fusion, cricopharyngeal myotomy, parathyroidectomy, carotid endarterectomy, neck biopsy, neck dissection, conservative laryngeal surgery (partial laryngectomy) or excision of a Zenker's diverticulum.

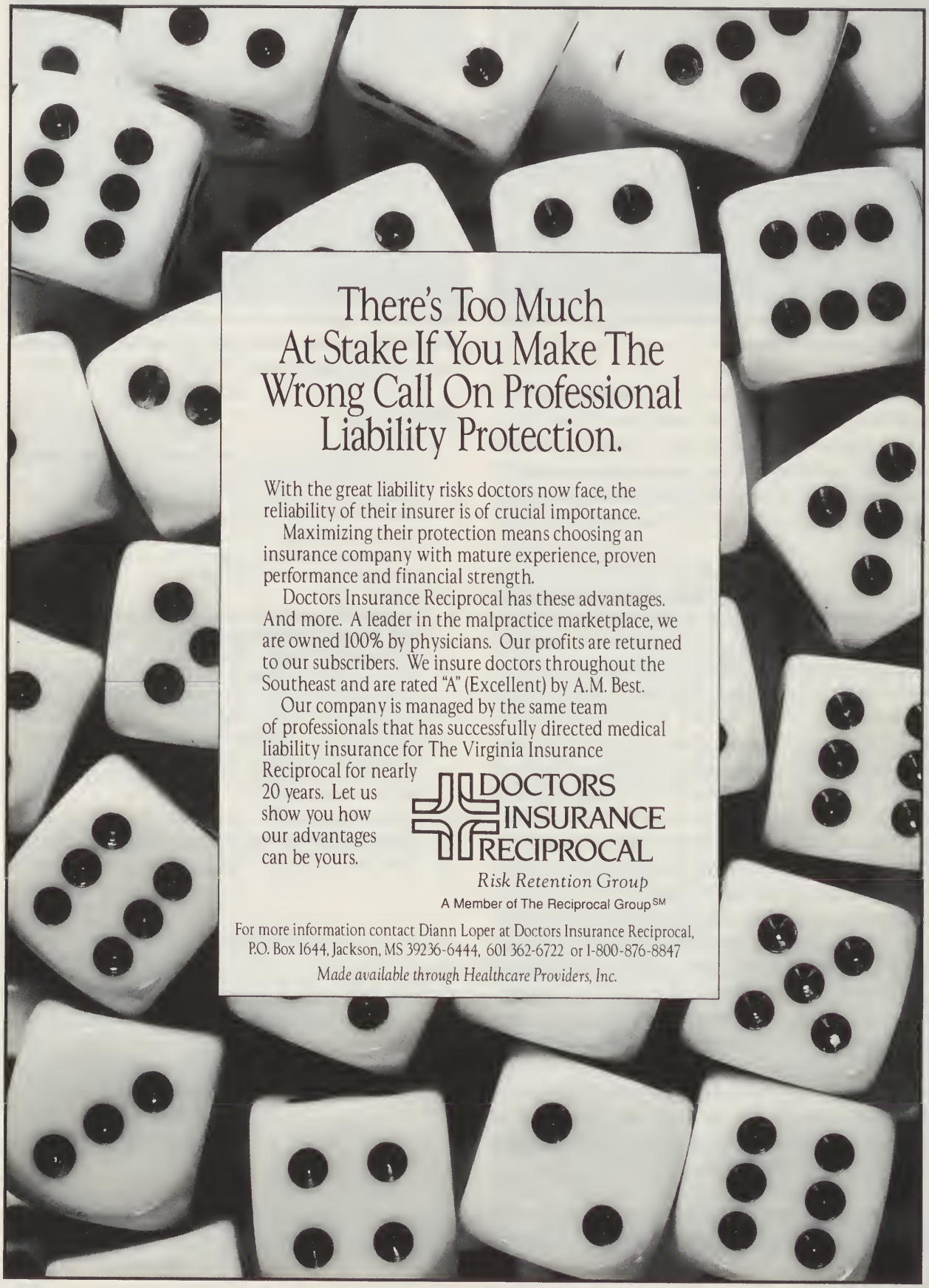
Summary: Electromyographic monitoring of vocal cord function during thyroidectomy is a very useful technique. It is non-invasive and provides valuable intraoperative data regarding the function of the recurrent laryngeal nerve.

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H. Vann Craig, M.D.

The President's Page

President's Finale

This is my last Presidents Page. I hope they have been of value to you and have at least given you something to think about. They were not a chore to write as subjects presented themselves during the year and I wrote about what I thought was best for our profession. They were brief because I have always felt that brevity is the soul of wit and none of us have time to read an epistle.

As a finale, allow me to invite you to the Annual Session of the Mississippi State Medical Association in Biloxi, May 14 - 17. This year an excellent program has been planed. The subjects to be covered are medical ethics, practice valuation, a review of federal legislation effecting medicine, and an update on HIV in Mississippi. Best of all, there is no registration fee. It's all free. The exhibits, the educational programs, and receptions - all at no charge.

Regardless of how you feel about the gaming industry, the fact is it has revitalized the Mississippi Gulf Coast by making it a DESTINATION. Large new hotels are being built or planned. For us, the convention goer, it creates a wonderful area in which to be entertained. Hopefully, this will increase the attendance at our Annual Session.

If you have an issue that you think should be addressed by MSMA, there are several ways that you can be heard. The Delegates from your local society, your Board of Trustees member, the MSMA staff, or I will be happy to assist you with a resolution. Let us know if we can help.

I look foward to seeing each of you in Biloxi and to personally thank you for the honor of being your President this year.

Vann



Sidney Oliver Graves, Jr., M.D.

November 30, 1920 - February 23, 1988

Sidney Graves was my friend. More than that, he was my mentor.

Oh, that I could be such a smo-o-o-oth politician!

To be blessed with longevity complete with an inquiring mind and good health is a gift God gives to only a few people. But to be given these extraordinary blessings is not enough - one must claim them, pounce upon them and run the course with them. Sidney Graves was such a man.

Privately, he was known as the Godfather of Mississippi Medicine. He was as a father to many of us.

Sidney's life was one of service. Service to his country in time of war, service to his patients, service to his community, service to medicine, and service to his church.

Sidney's roots grew deep into the State of Mississippi in many ways. He practiced medicine for 47 years, and was Chief of Staff of three hospitals, serving as chair of the board of trustees of all three. He was chair of the Mississippi State Board of Health, and instrumental in founding the Mississippi Foundation for Medical Care and the Medical Assurance Company of Mississippi, our own liability insurance company. He did this when other companies were abandoning that type coverage in the State. He was chair of the MSMA Board of Trustees and later MSMA President, American Medical Association Delegate and Chair of the AMA Southeastern Coalition.

He was President of the Natchez Rotary Club and in charge of their annual Christmas auction.

The list goes on and on. Obviously, Sidney worked hard at what he did. He demanded no less commitment from those of us who worked with him. If he found you a job, he expected you to do it and do it well.

In my 30 years of medical practice in Natchez, and my association with MSMA, there have been five presidents of the Association from Natchez. In the rotation that we share of North, Central, and South, there have only been ten opportunities for the South to have a president. He would say, "Boys, your work is cut out for you, Go get it!"

Dr. Curtis Moffett made these remarks about Dr. Graves at his funeral, "Allow me the privilege of getting down under the obvious creativeness and the progressive thinking - down to where he really lived - in his heart. You see, not only was Dr. Graves a man who possessed a profound faith in God, he took seriously God's mandate to be an active and participating disciple. He was rare person humble, yet determined; profound, yet simple; progressive, yet respect for tradition; a teacher, yet a learner."

Sidney loved the game of golf. In his spare time, he would slip away to the Belwood Golf Course and enjoy the companionship of his many golfing Buddies.

We will miss the warmth and physical presence of a gem of humanity. We will miss the keen insights of an enormous reservoir of experience. We will certainly miss him at the Mississippi State Medical Association.

Natchez had a tornado in the downtown area the morning of Sidney's funeral - He never was one to do anything quietly!! He always wanted us to put a new roof on Jefferson Street Methodist Church. I guess he'll finally get his way.

-H. Vann Craig

Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXIX, NUMBER 4
APRIL 1998

Our Noble Reason for Being

Driving back from the annual Legislative Forum in Jackson on Tuesday, January 13, was the usual four hour grind. One thing about it though, all that traveling time gives you plenty of opportunity to reflect on what you heard at the meetings. These days you don't sleep well after thinking all day about managed care, tort reform, "Who's got the tobacco money?", the Physician's Assistant bill, and then finally realizing just how little influence that Doctors actually wield with the Mississippi State Legislature.

So I arrived at my clinic the following morning short a couple of hours of much-needed beauty sleep, a bit grumpy, and immediately overwhelmed at the number of cars already in the parking lot. A heavier clinic load is always the punishment meted for leaving town for a day in the middle of the week. Today would be Monday all over again.

As I entered and walked down the hall toward my office I happened to glance into Exam Room 3. Suddenly I was disoriented. Everything had been moved. Every stick of furniture in my Exam Room was out of place.

I brusquely approached the nurses' station and said, (a little too loudly I'm sure), "Who moved all the furniture in my examination room???" My two medical assistants, Brenda and Barbara, answered rather sheepishly, "We did.... Do you not like it?"

"Who told ya'll you could do this?" I blared.

The nurses replied flatly, "We just thought it was a good idea. It needed doing. It looks better, don't you think?" My response was head-shaking and an exasperated, "Harrumph!"

I walked down the adjacent hall toward my cubby hole. Then I noticed Exam Rooms 1 and 2 had also been turned wrong-side out. They were mirror-image molecules of their former selves. I perceived another little surge in my serum catecholamine level.

Doc: "What kind of wild-hair did you two ladies get? Ya'll must not have had much to do yesterday while I was gone."

Barbara: "We thought after 10 years it was just time for a little change."

Doc: "I think I'd better turn around and go home and see what you did to the furniture in my house yesterday."

Brenda: "Yeah, you might ought to go check. We turned your library in to an extra guest bed room. Ha!"

These women did not apologize for being presumptuous furniture movers. They knew that if they had asked me about changing the rooms I would have vetoed the idea. I was too comfortable with the status-quo.

And they knew me well enough to realize that once I had let off steam, I would be okay with the idea. I would, as always, "go with the flow" . . . in time.

At any rate with a clinic brimming full of patients I was stuck with the changes for today at least.

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

I doggedly went to my office and sat at my desk. The words "10 years" played over like some endless-loop circuit in my brain.

That's right. We have been in this building for ten years this coming May and, old-fogy me, I still think of it as my "new clinic."

After cooling my heels momentarily I hurriedly got down to business with the first appointment in Exam Room 1. Then another distraction came to the forefront. There I found lying on the desk a copy of "A Credo for Our Patients," a little homily that ten years before we had typed-up, copied, laminated, and taped to the counter tops in each exam room.

Momentarily this object seemed a wrinkled-white ghost, an apparition from our past, whose presence I had not missed until today.

Obviously, over time it had slipped or been shoved behind the desk cabinet and been rediscovered when the nurses rearranged the office furniture. They had put at least one thing back into its original position.

After all, it does really seem like only a couple of years since we moved over here, all full of . . well, "oil and vinegar" at least. Faced with the daunting, prospect of making a solo-practice fly in this small country town, we were inspired by lofty goals and ideals.

Early on when our futures were not as certain, we took great pains to promote patient communication and satisfaction.

Thanks to my furniture-moving nurses I had rediscovered one of those early efforts that morning. I had intended that these Credos become a permanent part of our clinic's philosophy . . . a tickler so to speak, to remind us all of why we're here "playing Doctors and Nurses" in the first place. Our employment exists because of and for the benefit of THE PATIENT, not vice-versa.

It was disconcerting to me to learn that somehow all the copies of our patient Credo had wiggled their way out of our collective conscience and had been ignored by us all since our fledgling days. How could we have been so complacent?

Now with all these immediate physical changes imposed on me by my well-meaning employees, I felt back at square-one. But in so doing they had unearthed our little primary care clinic's reason for being.

Somehow this thought seemed to temper my momentary loss of autonomy.

On contemplation, I now perceive this incident (as trite as this may sound) as a metaphor for the changes in the identity of medicine as we have come to know it.

Managing these changes will be quite similar to traversing the human defense mechanisms known as the "Grief Process." After all, American Physicians are universally experiencing a real or perceived loss of some magnitude.

Thus far most of us have passed through Stage l: Shock and Denial; some of us are still wallowing in the Second Stage: Anger. I believe the majority of us are now Bargaining (Stage 3), trying to develop a strategy for staying afloat in these turbulent times.

When the Bargaining is over, some of us will no doubt slide into a Depression (Stage 4) that Prozac will not touch. A few of us will actually even leave medicine. At the very least most of us will suffer through some element of transient dysphoria.

Then perhaps, just perhaps, our innate resilience will quickly carry us to the Fifth and Final Stage of Grief: Acceptance.

These different coping mechanisms for dealing with extremely difficult situations will all last for varying lengths of time and may replace each other or exist at times side by side.

The constant undercurrent through all these stages is Hope, that glimpse of optimism that maintains us through these days of uncertainty.

One thing seems certain, Medicine is not going to change back to the entity we knew and loved in the "Good Old Days."

Our hope then is that we will emerge from this health care metamorphosis transformed into what Sir William Osler termed "the very best product of our profession", men and women whose stability of character and devotion to duty make one proud to be a Physician.

It is our hope also that as we make this evolution, we are fortunate enough to recognize our long lost noble reason for being when at last we rediscover it.

Here then is one clinic's version of "A Credo for Our Patients".

Our Patients Are. . .

OUR PATIENTS are the most important people in our clinic.

OUR PATIENTS are not dependent on us - we are dependent on them.

OUR PATIENTS are not an interruption of our work. They are the purpose of it

OUR PATIENTS are part of the clinic family, not outsiders.

OUR PATIENTS are not reducible to statistics. They are human beings with feelings and emotions.

OUR PATIENTS are not our adversaries. They are not here for arguments or debate.

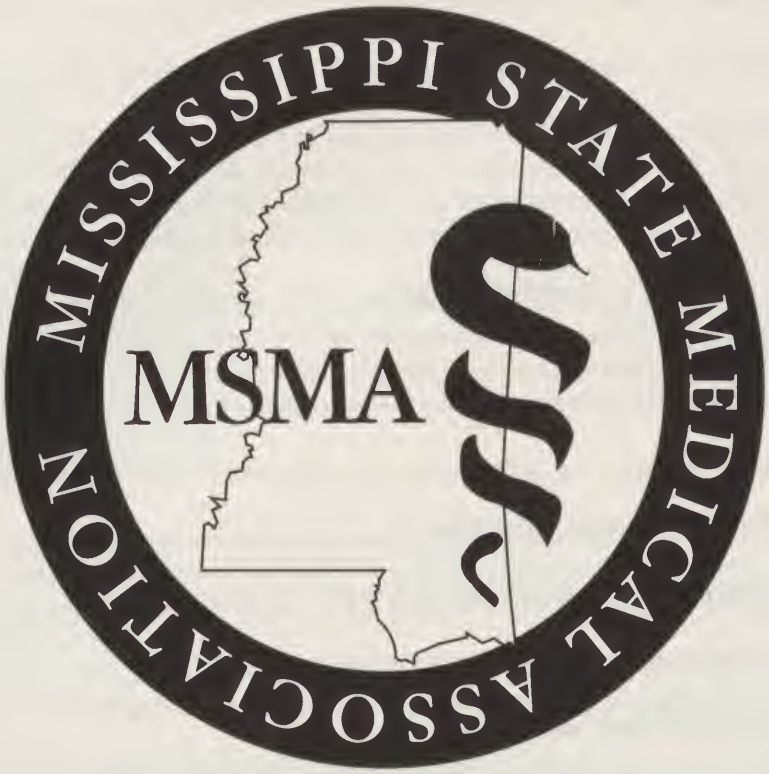
OUR PATIENTS are people who have chosen to bring their needs to us. It is our job to meet those needs.

OUR PATIENTS are deserving of courtesy, respect and total confidentiality.

OUR PATIENTS are deserving of the highest quality care we are capable of providing.

OUR PATIENTS are the lifeblood of this clinic.

-Dwalia S. South, M.D.
Associate Editor



130TH ANNUAL SESSION & SCIENTIFIC ASSEMBLY PRELIMINARY PROGRAM

May 13 - 17, 1998
Grand Hotel & Resort, Biloxi, MS

Supplement to The Journal Of The Mississippi State Medical Association, April 1998

GENERAL INFORMATION

REFERENCE COMMITTEES

All MSMA members may participate in reference committee hearings. Members are encouraged to participate in all references committees as policies of the Association are established. All meetings will be held consecutively in the meeting rooms Bay East 1, 2 & 3.

The Schedule is as follows:

2:00 PM	**MSMA Reference Committee on Constitution and Bylaws**
2:30 PM	**Reference Committee A**
3:45 PM	**Reference Committee B**

CME CREDIT

The MSMA Council on Scientific Assembly is accredited by the MSMA Council on Medical Education to sponsor intrastate continuing medical education for physicians. CME Credit hours for this session will be listed in the official program of the 130th Annual Session.

MSMA ALLIANCE PROGRAM

The MSMA Alliance will hold it 75th Annual Session Meeting, May 13-17, at the Grand Hotel & Resort. A copy of the meeting agenda is enclosed with the Distaff.

GOLF TOURNAMENT

A golf tournament will be held Friday, May 15. The tournament will begin at 1:00 PM at the Edgewater Bay Golf Course. Prizes will be awarded.

MSMA/ MSMA ALLIANCE MEMBERSHIP PARTY

The MSMA/MSMA Alliance **Membership Party** will be held on Thursday evening, May 14, at 6:30 PM in the Oasis Ballrooms B & D of the Grand Hotel & Resort. The MSMA Alliance will once again hold a silent auction with proceeds benefiting the AMA-ERF. Association members and guests will have the opportunity to browse through the items for auction and make their silent bid during the party. All items will be sold before the conclusion of the party. ***Dr. Sam and the Managed Care Blues Band*** will provide an evening of entertainment and dancing. The band's leader, Dr. Sam Bierstock, is a retired Florida eye surgeon who became so sick of modern medicine he reached for his harmonica for a radical cure. His repertoire includes songs like "You Picked a Fine Time to Leave Me, Blue Shield," "You're One Hip Mama 'Cause They Won't Pay for Two" and "Mastoid Sally" ("Grind, Sally, Grind"). Don't miss this panel of preferred multispecialty musician providers who can really sing the blues! The MSMA Membership Party will be hosted by Singing River and Coast Counties Medical Societies and Alliances.

THE PRESIDENT'S PARTY

The annual **President's Party** will be held, Saturday evening, May 16, in the Grand Casino Hotel in Biloxi, in the Oasis Ballrooms B & D from 6:00 PM to 8:00 PM. Tickets will be provided for a performance in the Grand Theatre, which is adjacent to the hotel, following the reception. However, the name of the show has not been announced at this time.

Members and their spouses are invited to all social events which are all complimentary.

MSMA 130th Annual Session and Scientific Assembly
May 13-17, 1998
Grand Hotel Resort• Biloxi, MS • 1-800-354-2450
Deadline for Guaranteed Reservations: April 13, 1998
PRELIMINARY SCHEDULE

WEDNESDAY, MAY 13

1:00 PM	Exhibitor setup: Technical & Scientific
	MSMA Registration opens
4:30	MSMA Board of Trustees Meeting

THURSDAY, MAY 14

8:00 AM	Grand Opening of Exhibits - Complimentary Continental Breakfast
	MSMA Registration
	MSMA Reference Committee Breakfast
9:00	MSMA House of Delegates
11:00	Alliance Pre-Convention Board Meeting/Luncheon
11:30	View Exhibits- Complimentary Sandwich Buffet
12:00 PM	Committee on Publications Luncheon
	Young Physicians Section Luncheon
1:00	MS Foundation for Medical Care Membership Meeting
	Preview Auction Items
2:00	MSMA Reference Committee on Constitution and Bylaws
2:30	MSMA Reference Committee A
3:45	MSMA Reference Committee B
6:30	MSMA/ MSMA Alliance Membership Party

FRIDAY, MAY 15

7:00 AM	MS EENT Association Breakfast
	MS OB/GYN Association Breakfast
7:30	View Exhibits- Complimentary Continental Breakfast
	MSMA Board of Trustees Breakfast
8:00	MSMA Registration
	Alliance Registration
8:30	MSMA Past Presidents' Breakfast
	MSMA Alliance Welcome & Coffee
9:00	MSMA Alliance House of Delegates
	MSMA Plenary Session
12:00 NOON	MSMA Alliance Luncheon
	MS Academy of Family Physicians Lunch
	MS Neurological Society Lunch/Meeting
	MS ASIM Association Luncheon
	Presentation of Exhibit Registration Prizes- Exhibit Hall
1:00 PM	MACM Golf Tournament - Edgewater Bay Golf Course
2:30	Documentation/Fraud & Abuse Workshop for Physicians

FRIDAY, MAY 15 - Continued

2:30	MSMA Alliance Post-Convention Board Meeting
5:00	MSMA Past Presidents' Reception
6:00	University of Mississippi Medical Alumni Association- MS Art Museum in Biloxi
7:00	Dinner-Mary Mahoney's
9:00	Ice Cream & Coffee- Sponsored by Southern Medical Association

SATURDAY, MAY 16

7:30 AM	Women in Medicine Caucus Breakfast/ Meeting
	MSMA Board of Trustees Breakfast
	MS Chapter, ACS, Officers and Board of Governor's Breakfast
8:00	MSMA Registration
	MSMA Alliance Past Presidents' Breakfast
8:30	MSMA Fifty Year Club Breakfast
9:00	MSMA Plenary Session
10:00	MS Dermatology Society Meeting
12:00 NOON	MS Chapter, American College of Emergency Room Physicians Lunch/Meeting
	MS Association of Pathologists "
	MS Chapter, American College of Surgeons "
	MS Psychiatric Association "
12:30	MS Association of Public Health Physicians Lunch/Meeting "
3:00	MPIC - Annual Stockholders Meeting
3:30	Central Medical Caucus
6:00	MSMA President's Reception for Members and Guests
10:00	Dr. Hopson's Dessert Party

SUNDAY, MAY 17

7:00AM	Board of Trustees Breakfast
	Women in Medicine Breakfast
7:30	Membership Continental Breakfast
8:00	Protestant Services
9:00	MSMA House of Delegates
12:00 NOON	Meeting adjourns

"Medical Practice in Mississippi: Current Issues in Preventive Health, Ethics and Government"

EDUCATIONAL PROGRAM

PLENARY SESSION

Friday, May 15 • Oasis Ballroom B & D

9:00 a.m. **Panel: "Preventive Health in the Case Management of Stroke, Hypertension, Obesity and Heart Disease"**

- **Stroke**
  David Lee Gordon, M.D., Associate Professor, School of Medicine
  University Medical Center Department of Neurology
- **Hypertension**
  Errol D. Crook, M.D., Assistant Professor, School of Medicine
  University Medical Center Department of Medicine
- **Obesity**
  James Clinton Smith, M.D., Assistant Professor, School of Medicine
  University Medical Center Department of Pediatrics
- **Heart Disease**
  Charles K. Moore, M.D., Assistant Professor, School of Medicine
  University Medical Center Heart Station

10:00 a.m **"HIV/AIDS in Mississippi"**
Ed Thompson, M.D., State Public Health Officer
MS State Department of Health

11:00 a.m. **"Medical Practice Valuation for Physicians"**
Gregory D. Anderson, CPA, CVA, Senior Manager
Horne CPA Group

Noon **Adjourn**

PLENARY SESSION

Saturday, May 16 • Oasis Ballroom B & D

9:00 am **"Professional Liability and Your Practice"** - *Sponsored by MACM*
Michael H. Gendel, M.D., Associate Medical Director, Colorado Physician Health Program; Clinical Associate Professor of the University of Colorado Psychiatric Health Services Center

10:00 am **"Medical Ethics"**
(Speaker unconfirmed at press time, to be announced in next program)

11:00 am **"Current National Health Care Legislation and How it will Impact Medical Practice Plans"**
Melissa Edwards, Assistant Director of Legislative Affairs
American Medical Association

Noon **Adjourn**

Plenary Programs Planned by MSMA's:
Council on Scientific Assembly

TECHNICAL EXHIBIT

MSMA 130th Annual Session

EXHIBITORS (as of JOURNAL MSMA Press Date)

Abbott Laboratories
American Academy of Physician Assistants
Apria Healthcare
Chandler-Sampson Insurance, Inc., representing the
THE DOCTORS' COMPANY
Continue Care Home Health
Davis & Goulet Insurance, Inc.
Doctors' Insurance Reciprocal
Doctors' Network of America
Executive Planning Group
Foundation for Medical Care
Health Link
Horne CPA Group
Humana Military Health Services
Knoll Pharmaceutical Co.
Medical Assurance Company of Mississippi
Medical Pathology Laboratory, Ltd.
Memorial Hospital at Gulfport
Merck & Company, Inc.
Mid Delta Health Systems
MS Academy of Physician Assistants
MS Baptist Health Systems
MS Managed Care Network
MSMA Benefit Plan & Trust
MS Methodist Rehabilitation Center
MS Organ Recovery Agency
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Mississippi State Medical Association Alliance

75th Annual Session
May 13-17, 1998
Grand Hotel & Resort
Biloxi, MS

WEDNESDAY, MAY 13

3:00 PM - 5:00 PM	Registration - 2nd Level

THURSDAY, MAY 14

9:00 AM - 4:00 PM	Registration - 2nd Level
11:00 AM	Pre-convention Board Meeting/Luncheon
1:00 PM - 5:00 PM	View AMA-ERF Auction items
6:30 PM	MSMA/ MSMAA Membership Party & AMA-ERF Auction

FRIDAY, MAY 15

8:00 AM - NOON	Registration - 2nd Level
8:30 AM	Alliance Welcome and Coffee
9:00 AM	House of Delegates
12:00 PM	Luncheon/ Installation of Officers
2:30 PM	Post-convention Board Meeting

SATURDAY, MAY 16

8:30 AM	MSMAA Past Presidents' Breakfast
6:00 PM	MSMA President's Reception

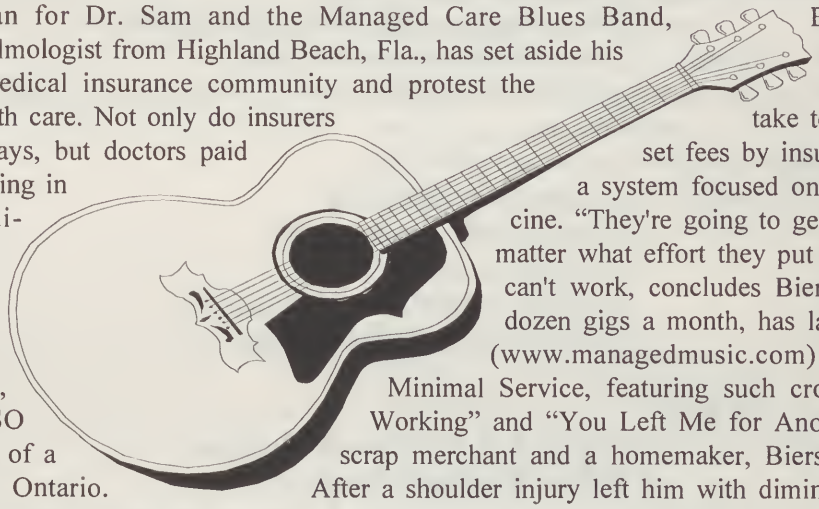
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featuring

Dr. Sam and The Managed Care Blues Band
Integrated Music Delivery System

Thursday, May 14, 1998

Still waiting for reimbursement for that hammertoe operation six years ago? Dr. Sam Bierstock may not be able to persuade your insurance company to pay up, but he will feel your pain, and he'll probably leave you in stitches-not the medical kind, as he kicks into a bluesy number like "You Better Come Home With Me Baby, 'Cause We Ain't Allowed to Stay Overnight," he wails.



Frontman for Dr. Sam and the Managed Care Blues Band, Bierstock, 50, a retired ophthalmologist from Highland Beach, Fla., has set aside his scalpel to needle the medical insurance community and protest the pitfalls of managed health care. Not only do insurers take too long to repay patients, he says, but doctors paid set fees by insurers feel as if they are working in a system focused on profits, not sound medicine. "They're going to get a fixed amount no matter what effort they put in or how good they are it can't work, concludes Bierstock. He plays more than a dozen gigs a month, has launched a Website (www.managedmusic.com) and just released a CD, Minimal Service, featuring such crowd-pleasers as "Got my MSO Working" and "You Left Me for Another Plan".

The son of a scrap merchant and a homemaker, Bierstock was born in Kitchener, Ontario. After a shoulder injury left him with diminished feeling in his fingers, he gave up his practice in Rhinebeck, N.Y., in 1992 and moved to Florida, where he became a medical management consultant. Frustrated in that job by doctors' low morale, Bierstock, who had played trombone, guitar and banjo as a kid, quit to form his blues band earlier this year (the keyboardist, a dentist, is the only other "doc" on board). "If I tried to explain managed health care to the public seriously, I'd put everybody to sleep," says Dr. Sam. "This way it's great fun, and we're educating the public."

(All social events are complimentary for MSMA members and their spouses)

Mississippi Wins Awards-Southern Medical Auxiliary Charlotte, North Carolina

Lee CountyAlliance won 2nd place in Health Education for Breast Cancer awareness Project. North Central Alliance won third place for Doctors' Day for providing free mammograms and planting of trees in honor of their doctors.



Merrell Rogers, Vice President of Doctors' Day, SMA Auxiliary, presented the award for the Best State Project for Doctors' Day to Jane Ladner, MSMA Alliance President. The project addressed domestic violence.



Peggy Crawford, SMA Auxiliary Health Chairman for Mississippi, with the winning posters.



Enjoying the convention are left to right James C. Waites, M.D., Jo Waites, Jean Hill and Jane Ladner. Much to the Alliance's delight, Dr. Waites serves as Special Advisor to the SMA Auxiliary for the Southern Medical Association.



Governor Fordice recently signed a proclamation commemorating Doctors' Day, March 30, 1998. Shown with the Governor are Jane Ladner, President of the MSAA and Rose Lee Robinson, MSMAA State Health Promotions Chairman.

Quality Measurement in the Physician's Office

Providing good patient care, managing time, and having profitable operations have been the primary foci of clinic concerns as we "practice" medicine. Now comes the onslaught of managed care companies (in the near future), government payers, and credentialing agencies with requirements of various "oversight" requirements.

Most clinical office practices, unless intertwined with a large group association or network lack the expertise, understanding, time, or staff to undertake such assessment or reporting. In localities with a heavy managed care penetration, accreditation reviews usually require a site visit to the office and an extensive assessment of components of provisions of outpatient care. This usually is an administrative hassle and extra costs for the physicians and their staff.

On the other hand, systemic assessment of providing quality care, acceptable and timely access to care, and efficient operations will give measurements which can be used to place a practice in a strong position when negotiating for contracts with managed care organizations, meeting credentialing requirements, or supporting treatment methods when reimbursement is questioned.

In addition to new outpatient Medicare quality improvement projects being offered, the Foundation plans to introduce a new program it will offer to our physicians at a nominal cost to meet these needs for initiating office assessment and measurements. The Foundation's annual session Thursday, May 14, in Biloxi traditionally held in conjunction with the MSMA annual meeting, will include a presentation by Dr. David Hall of Natchez on "Quality Improvement in the Physician's Office." Dr. Hall, a board member since 1995, also serves on the Board's executive committee. If you have questions or suggestions about this subject, please contact me at 601-354-0304 or 1-800-855-0500.

— James S. McIlwain, M. D.

Upcoming Events

Quality Showcase '98 will be presented by the Foundation Friday, May 1, at the Lakeover Center in Jackson. Speakers on both the national and state level will highlight this one-day seminar focusing on exemplary quality improvement projects involving Mississippi hospitals. Special emphasis will be on stroke prevention and education, coinciding with the annual May observation of Stroke Prevention Awareness Month.

Keynote speaker will be Dr. David Lee Gordon, associate professor of neurology at the University of Mississippi Medical Center who is well-known throughout the state and nation as a stroke expert.

Motivational speaker will be Bob Nichols, news anchor at WPEC TV 12 in West Palm Beach, Florida, who travels throughout the country speaking and working with stroke survivor groups. His career and life was interrupted by a stroke in 1984 which left him paralyzed on the left side. After two years of intense therapy, he fully recovered only to be hit by another stroke in February 1994. Again he recovered, and his victory over stroke led to his current national work with the American Heart Association. He is the subject of a nationally distributed video on stroke recovery.

Exhibits featuring quality improvement projects will be displayed by a number of hospitals, and announcement of the 1998 FMC Quality Awards will be made.

Any physician interested in attending Quality Showcase '98 is invited to contact the Foundation for further information.

The Foundation's Annual Session, traditionally held in conjunction

with the State Medical Association annual meeting, will be Thursday, May 14, at 1 p.m. at the Grand Casino Hotel in Biloxi. A highlight of the meeting will be a presentation by Dr. David Hall of Natchez on "Quality Improvement in the Physician's Office." Dr. Hall has been on the Foundation board since 1995 and is currently serving as the treasurer.

Announcement of newly elected board members will be made at this meeting, as will the recipient of the A. A. Derrick Award, which recognizes an outstanding physician supporter of the quality improvement program.

The Foundation is ON LINE at www.mfmc.org.

With the INTERNET becoming a common means of sharing and accessing information for many Americans, the Foundation has jumped on the band wagon by developing its own web site at www.mfmc.org. The Foundation hopes to use its site to share with users in the health care field, as well as the general public information concerning the Foundation's history, services and products.

The site's home page features a brief history and purpose statement of the Foundation and has multiple resource links to each of the site's pages which include: About FMC; Events/Calendar; What's New; Frequently Asked Questions; Publications; Services; Feedback; Officers/Directors; and Resource Links.

The web site should provide users with a faster means of communicating and accessing information from the Foundation. The web site will be updated periodically and any suggestions and comments to help improve the web site are welcome. Visit us soon at www.mfmc.org.

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J. Edward Hill, M.D., AMA Trustee, of Tupelo, recently addressed the full Senate Finance Committee. Dr. Hill provided testimony on private contracting provisions in Medicare, in favor of repealing the Balanced Budget Act of 1997. The AMA strongly believes that every Medicare beneficiary should have the unrestricted right to spend his or her money to purchase health care services outside of the Medicare program.

John R. Harper, M.D. of Taylorsville, **Frank W. Bowen, M.D.** of Carthage, and **William Douglas Owens,** M.D. of Morton, have completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians (AAFP), the national association of family doctors. Dr. Harper has been an active AAFP members since 1976, Dr. Bowen since 1961 and Dr. Owen since 1994.

Michael D. Fromke, M.D., a neurosurgeon at Hattiesburg Clinic, recently taught a course on Microendoscopic Diskectomy at the annual meeting of the Joint Section on Disorders of the Spine and Peripheral Nerves in Rancho Mirage, California. Microendoscopic Diskectomy is an outpatient procedure for the treatment of sciatica caused by ruptured lumbar disks. Dr. Fromke was the first neurosurgeon to bring this procedure to South Mississippi. He received his medical degree and completed a residency in neurosurgery at the University of Tennessee in Memphis.

Richard A. Conn, M.D. of HubSouth Orthopaedics and Rheumatology has successfully completed the recertification examination for the American Board of Orthopaedic Surgery. Recertification by the ABOS recognizes an orthopaedic surgeon's ongoing proficiency in the field of orthopaedic surgery. Dr. Conn established the Southern Center for Arthritis and Rheumatic Diseases in 1984 after completion of Fellowship training in Arthritis and Joint Replacement Surgery at the Mayo Clinic in Rochester, Minnesota. Dr. Conn is the President of HubSouth Medical Group, PLLC, headquartered in Hattiesburg. He recently presented scientific papers in Tampa, Florida relative to advancements in the diagnosis and treatment of arthritic knee joint disease. Dr. Conn is the founder of the Southern Center for Arthritis and Rheumatic Disease. He also presented an analysis entitled "Adapting to the Changes of Managed Care" at the 1998 winter meeting of the National Orthopaedic Alliance in Vail, Colorado. He has been selected as a consultant to the National Orthopaedic Alliance. The National Orthopaedic Alliance assists orthopaedic surgeons in the practice management decisions relative to ongoing changes in the field of orthopaedic surgery.

John C. Mutziger, D. O., an osteopathic Family Practice physician in Meridian, has completed the 150 hours of continuing medical education (CME) necessary to maintain membership in the American Osteopathic Association (A.O.A.). Dr. Mutziger is a graduate of the University of Health Sciences College of Osteopathic Medicine and served his internship in Kansas City, Missouri at the University of Health Sciences. He is board certified in Family Practice and is on staff at Riley Memorial Hospital.

George D. Ladner, M.D. announces the relocation of his office for the practice of Psychiatry to 640 Lakeland East Drive, Suite E, Jackson, Mississippi, 39208.

S. Jay McDuffie, M.D., of Nettleton, was commended for his dedication to medicine and years of service with House Concurrent Resolution 88. Dr. Nettleton was serving as "Doctor of the Day" when the House of Representatives honored him. Part of the resolution read, "WHEREAS, S. Jay McDuffie was educated in the public schools of Nettleton, having graduated from Nettleton High School where he was valedictorian of his class before obtaining his Bachelor of Science degree from Mississippi State University in 1943, and a Bachelor of Arts degree from Oglethorpe College in Atlanta, Georgia, in 1946, where he met his beautiful wife, Dorothy Hooks (Miss Dot), who has now been his steady partner and companion for 53 years; and WHEREAS, S. Jay McDuffie completed medical course work in 1947, at the University of Mississippi in Oxford and in 1949, earned his medical degree from the University of Tennessee, Memphis, interning at Methodist Hospital in Memphis; and WHEREAS, Dr. S. Jay McDuffie returned home to his beloved Nettleton, where he began the solo practice of family medicine in October 1950, and continues that practice today, which still includes an extraordinary personal touch, the latest in medical science and fre-

quent house calls; and WHEREAS, Dr. McDuffie is a revered community man, an honorary lifetime staff member of the North Mississippi Medical Center Staff in Tupelo, a longtime member and past delegate to the American Medical Association and former vice president of the Mississippi State Medical Association and President and Secretary-Treasurer of the Northeast Mississippi Medical Association: NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF THE STATE OF MISSISSIPPI, THE SENATE CONCURRING, That we hereby express our undying gratitude to Dr. S. Jay McDuffie for 47 years of continuous medical practice and excellent citizenship provided to the people of the State of Mississippi.

Larry D. Field, M.D. and **Felix H. Savoie, III, M.D.** recently served as co-guest editors of two issues of *Operative Techniques in Sports Medicine*. The October 1997 issue of the journal was entitled "Advanced Arthroscopic Techniques in Shoulder Surgery." More recently, the January 1998 issue was entitled "Elbow and Wrist Arthroscopic Procedures in the Athlete." Dr. Field recently gave three scientific presentations at the Current Concepts of Shoulder and Elbow Surgery in Tampa, Florida. His talks were entitled "Arthroscopic and Mini-Open Rotator Cuff Repair," "Advanced Procedures in Elbow Arthroscopy," and "The Arthroscopic Evaluation and Treatment of Ligament Injuries of the Shoulder." Dr. Savoie recently gave three scientific presentations at the Arthroscopic & Reconstruction Surgery 1998 at Scottsdale, Arizona. His talks were entitled "Techniques for Arthoscopic Rotator Cuff Repair," "Thermal Capsular Shrinkage for Shoulder Instability," and "The use of the Mitek Panalok Absorbable anchor in Arthroscopic Bankart Repairs." Dr. Savoie also recently gave two talks on Sports Medicine: Treatment, Controversies and Problem Solving in Marco Island, Florida. His talks were entitled "Arthroscopic Repair for Anterior Instability" and "Arthroscopic Treatment of Elbow Injuries."

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Hal T. Liddell, M.D. successfully passed the recertifying examination as a Diplomate of the American Board of Urology. Recertification is time-limited, for a period of 10 years from the date of initial board certification. Dr. Liddell will be included in the next edition of the Official ABMS Directory of Board Certified Medical Specialists. Dr. Liddell practices at HubSouth Urology Clinic, a division of HubSouth Medical Group, PLLC.

Walter Cosby, M.D. has been made a Fellow of the American Academy of Otolaryngic Allergy. He met the requirements by passing the Academy Fellow Examination. Dr. Cosby has practiced in the Columbus area since 1987 and, with his partner **Dr. Joseph Boggess**, also maintains offices in Starkville and Amory.

Steven J. Miller, M.D. recently received a three-year appointment by the American College of Surgeons as cancer liaison physician for the Commission on Cancer. Dr. Miller, a native of Moss Point, graduated from the University of South Alabama College of Medicine and completed his surgical training at the University of Washington Medical Center in Seattle. A general, vascular and thoracic surgeon, Dr. Miller is certified by the American Board of Surgery and is in private practice with offices in Pascagoula and Ocean Springs. Dr. Miller joins a network of more than 2,000 physicians who provide leadership and support to the Approvals Program regarding cancer activities. The Commission on Cancer was established in 1922 and represents more than 35 other cancer-related organizations that approve more than 1,450 cancer programs in health care institutions across the country. The commission reviews each health care institutions cancer programs for conformity to establish standards and encourages participating hospitals to equip and staff themselves so they are able to provide the best diagnosis and treatment of cancer.

David Lee Gordon, M.D., associate professor of neurology and medical director of the UMC Com-



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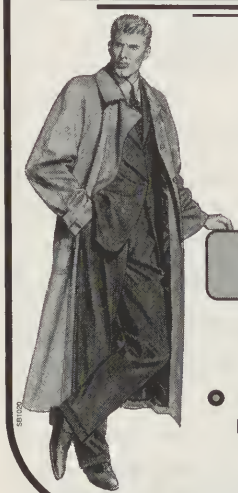
prehensive Stroke Program, received the Stroke Council Liaison of the Year Award at the AHA's Joint Conference on Stroke and Cerebral Circulation meeting in Orlando for his work in promoting stroke awareness, prevention and treatment in Mississippi as the state's AHA Stroke Council Affiliate Liaison. The Mississippi Affiliate of the AHA received the Stroke Affiliate of the Year Award. Gordon has served as the liaison to the Mississippi AHA Affiliate since 1992. In addition to his work with the Mississippi Affiliate, Gordon is also the current chair of the Stroke Task Force for the newly formed AHA Southeast affiliate consisting of Georgia, Tennessee, Alabama, Louisiana, and Mississippi. He also serves on the executive committee of the AHA Stroke Council, as editor of the Stroke Council Newsletter, and is the only neurologist on the AHA's national Secondary Prevention Project Team.

Jack Sariego, M.D. and **Razee Ahmad, M.D.** spent a little time in the slammer as part of Newton Regional Hospital's "Bail a Buddy" fundraiser. The fundraiser earned about $2,500 for the "Knights in Armor project, which raised a total of about $4,000 to provide ballistic vests for every law enforcement officer in the county who wanted a vest but did not have one.

Bobby L. Graham, Jr., M. D., of Jackson, has been elected a Fellow of the American College of Physicians (ACP), a society of internists. Dr. Graham is a medical oncologist in private practice with Jackson Oncology Associates, PLLC.

Catherine P. Hirsch, M.D., Board Certified, Internal Medicine; Board Certified, Gastroenterology, and **F. Steven Orleans, M.D.,** Board Certified, Internal Medicine; Board Certified, Gastroenterology, announce the merging of their practices as Regional Digestive Specialists, P.C., specializing in gastroenterology.

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The Mississippi State Department of Health Central Cancer Registry: Purposes and Potential Uses

Alan Penman, MB, ChB, MSc
Judy Moulder, MHS, RRA, CTR
Bruce Brackin, MPH

At some point — preferably sooner rather than later — we must ask: what is the point of collecting and reporting cancer data to the Mississippi State Department of Health (MSDH) Central Cancer Registry (CCR)? What will it be used for? In this short article, we will discuss briefly what we think will be the main uses of the MSDH-CCR in both the short and long terms. These views are our own, but they are based on published reports describing uses of such data in other states and on discussions with other epidemiologists in The Health Department and with clinicians and oncologists around the state.

The state's central population-based cancer registry will provide the capability to:

- determine cancer incidence rates in the state and compare them with national and regional rates.
- identify high-risk population groups or geographic areas within the state.
- determine the burden of cancer for policy-making, planning, and resource allocation.
- monitor trends in incidence.
- provide a centralized cancer database for further epidemiologic research.
- provide statistical information on cancer for public use.

Most of these are self-explanatory, but a few additional comments are in order. For this, the uses have been grouped into two categories, short-term and long-term.

Short term

Quantifying the burden of cancer in the state by determining the number of new cancer cases each year and their distribution across the state by county and, eventually, by census tract

In doing this, numbers of incident cases will be compared to state and county estimates derived from the SEER program.[†] Until now the MSDH has relied on SEER estimates as its only source of cancer incidence data, and we will continue to use these estimates until reporting to the CCR is consistent and complete from year to year. It will be important to compare actual with expected numbers, to look for differences that could suggest either under-reporting to the CCR or state rates that are higher or lower than national rates.

Determining population groups at higher than average risk for developing cancer

Nationally, there are marked racial disparities in the incidence and mortality for several types of cancer. This is obviously relevant to Mississippi with its large African-American population. For example, mortality from cervical cancer remains too high. In Mississippi, approximately 60 women die of this cancer each year, and the mortality rate is three times higher in black females than in white females. Prostate cancer, which kills more than 400 men in the state each year, has a

mortality rate that is twice as high in black males as in white males.

For both these cancers, without exact incidence data for the state it is very difficult to determine whether the differences in mortality rates result from different incidence rates, different tumor biology (a more aggressive type of cancer), differences in access to screening/treatment services, or different responses to treatment.

Incidence data combined with mortality data (to give a deaths/incidence ratio) and stage at diagnosis data (early/late stage ratio) can be used to identify groups presenting late for diagnosis

† The Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute collects data from 9 cancer registries in 5 states and 4 metropolitan areas covering approximately 9.5 percent of the U.S. population. These data are "reasonably representative" of the U.S. population.

Because of problems with access to screening or treatment services or other barriers, these groups could then be targeted for more intensive cancer education and screening programs and/or improved treatment services.

Responding to community cancer concerns

This is not usually listed as a specific purpose of a cancer registry, but it is certainly one of the main uses of the data. Concern over an apparent excess of cancer in general (or an excess of a specific cancer type) in a local community is a common subject of calls to the MSDH. Methodologic answers to these questions rarely satisfy the questioners. Cancer "clusters" are almost always the result of chance variation in local cancer rates.

For example, we are currently responding to an apparent excess of breast cancer cases in an occupational setting in Northeast Mississippi. At present, epidemiologic methods can only give this group of concerned citizens a general estimate of how likely or unlikely this is to occur. The ability of the CCR to produce small area rates will allow us to give much more specific estimates of how many cases might be expected, though it does not solve the problem completely.

Provide data to inform legislators, policy-makers, and public health planners

Data from the CCR can be very useful for informing legislators and other decision-makers who need to prioritize needs and allocate resources for cancer prevention and control. To assist in determining the need for new or expanded services, state-specific incidence rates can be used to calculate actual and projected numbers of cases.

In making projections, it is important to remember that even if age-specific incidence rates are not increasing, overall cancer numbers will increase as the state's population ages. By incorporating data on the effectiveness of cancer prevention programs, an estimate can be made of the annual number of new cases that could be prevented if intervention goals are reached. This information can even be combined with cost data to show the cost-effectiveness of cancer prevention.

Legislative and policy-making decisions are increasingly driven by data. The more the data relate to this state — or to districts or counties in this state — the more useful and acceptable it is to decision-makers.

Improving communication of cancer risk and the ability of people to assess personal cancer risk

The public perception that there is an "epidemic" of cancer and that national cancer control programs have failed is increasingly fueled by media reports that there is "something seriously wrong" in the environment. However, overall mortality from cancer has improved since 1991, survival rates for many cancers are high (at least, if treated reasonably early) and continuing to improve, and definite evidence of widespread environmental carcinogens is lacking.

Although the cumulative personal lifetime risk of cancer (all types) is 1 in 3, the type-specific cancer risk at any specific age for the average person who has no known risk factors such as use of tobacco or family history is low. As mentioned above, because cancer is more common with increasing age the overall cancer burden will increase as the population ages, even though age-specific incidence rates may not be increasing.

Another misperception relates to the time required for cancer to develop: the latency period for most cancers is at least 15 years and usually 20 years or longer. Communication of information on cancer and on personal cancer risk, which can be derived from data in the CCR, is greatly needed.

Long-term uses

Providing baseline data for cancer prevention and control efforts so that changes in incidence rates can be monitored and the effectiveness of cancer screening and control programs evaluated

Even without a statewide cancer screening policy or program we know that screening for breast and cervical cancer is widely practiced in the state, but there is no way of monitoring its impact. We would expect breast cancer incidence rates to increase and the proportion of late-stage tumors to fall as more early-stage, subclinical

cases are discovered through the screening process. We can also expect screening for prostate cancer to become more widespread.

In addition, there is increasing interest in screening for a number of other cancers such as ovarian, colorectal, esophageal, and skin (both basal cell carcinoma and malignant melanoma). Reliable baseline rates for all these need to be established, preferably before new screening programs are established or existing programs expanded.

Three to five years of data are usually needed for trend patterns to become apparent and to allow annual rates to be stabilized by aggregating and averaging multi-year data. This is especially important for the less common cancers for which small numbers in any one year can give misleading high or low rates that fluctuate from year to year.

References available on request

Alan Penman, MB, ChB, MSc is an Epidemiologist, with the Mississippi State Department of Health (MSDH).

Judy Moulder, MHS, RRA, CTR is Director of the Central Cancer Registry with the MSDH.

Bruce Brackin, MPH is Deputy State Epidemiologist with the MSDH.

What can the Central Cancer Registry do for Mississippi's health professionals?

- determine cancer incidence rates in the state and compare them with national and regional rates
- identify high-risk population groups or geographic areas within the state
- determine the burden of cancer (numbers of new cases) for policy-making, planning, and resource allocation
- monitor trends in incidence
- provide a centralized cancer database for further research
- provide statistical information on cancer for public use



Central Cancer Registry
Mississippi State Department Of Health
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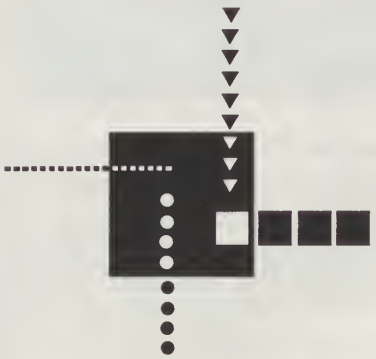
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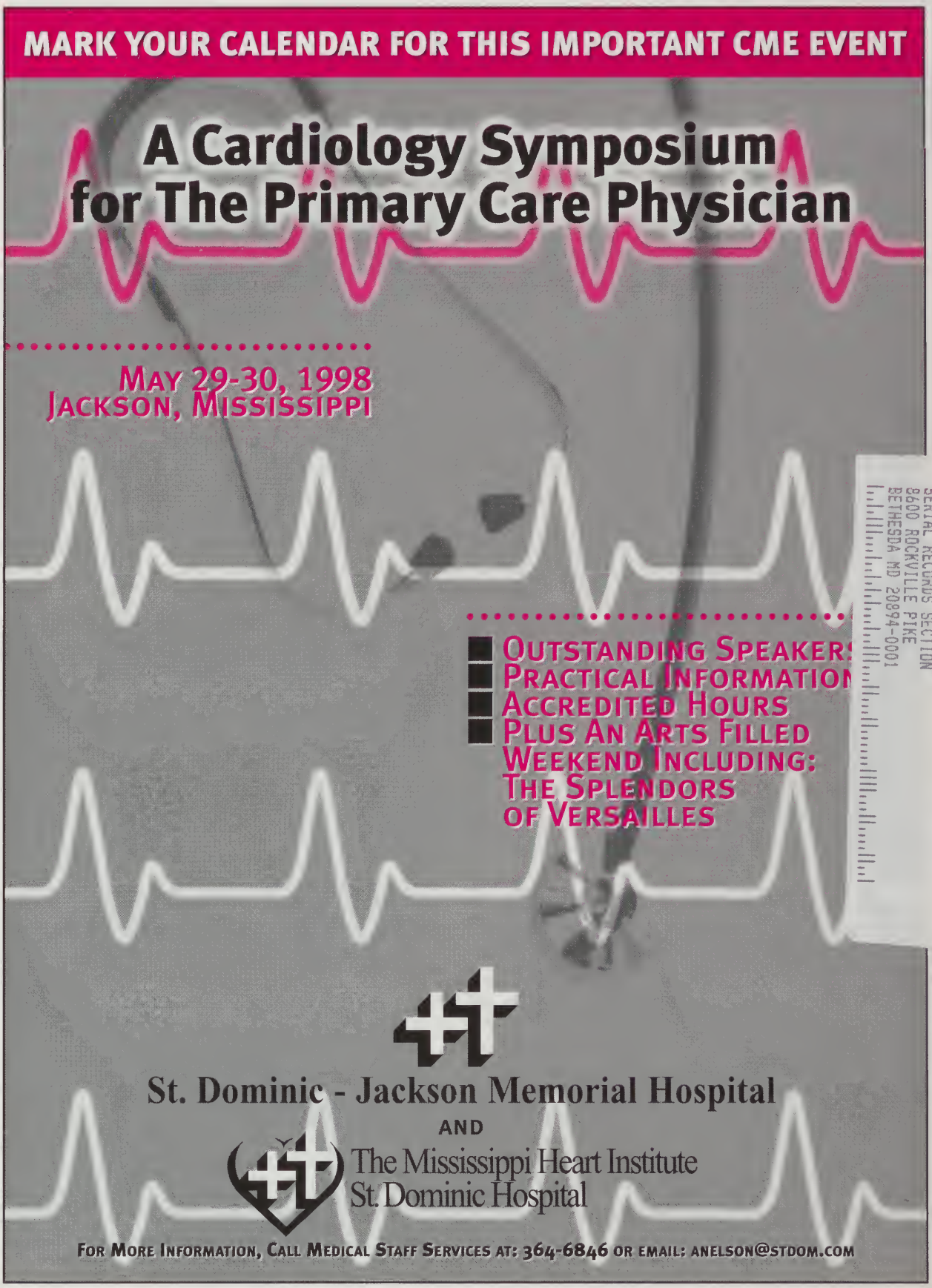
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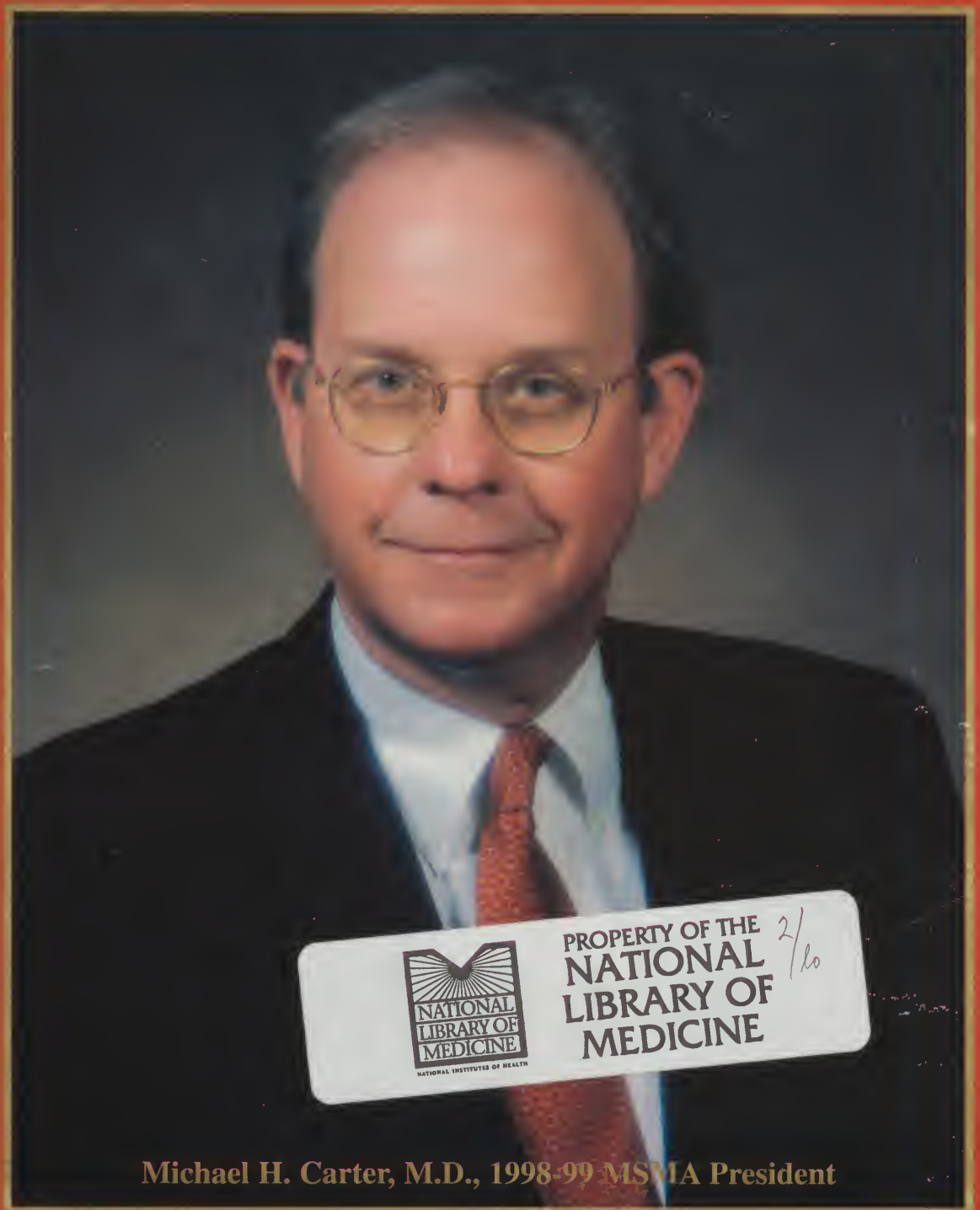
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Role of Technitium-99M Sestamibi Myocardial Imaging in the Emergency Department Evaluation of Chest Pain

Richard L. Summers, M.D.
Brett Tisdale, M.D.
James C. Kolb, M.D.
Lou Ann H. Woodward, M.D.

Key Words: Sestamibi, Chest Pain, Myocardial Infarction

Abstract

The use of technetium-99m sestamibi myocardial imaging is rapidly becoming a state of the art methodology for the emergency department evaluation of patients with chest pain. The following case report represents the first emergency department sestamibi scan ordered at the University of Mississippi Medical Center and is used to discuss the logistics and indications for such tests. A general guideline for ordering sestamibi scans has been developed for use in the emergency department.

Case Report

History of Present Illness: A 32 year old white male presented to our Emergency Department complaining of left-sided chest pain that began while driving to work approximately 1.5 hours prior to admission. The patient stated that the pain was very sharp in nature at its onset, radiated down his left arm, and was associated with mild dyspnea. There was no associated nausea, vomiting, or diaphoresis. He stated that the pain, although initially very sharp, was currently a dull ache in the left chest. The patient further stated that he had a similar episode of chest pain approximately two weeks ago but did not seek medical attention at that time.

Past Medical and Social History

The past medical history was remarkable for peptic ulcer disease for which the patient took omeprezole. He had no history of diabetes mellitus or hypertension. His family history revealed that his father had coronary artery disease, but the patient did not know if his father had ever sustained a myocardial infarction. The social history was significant for one pack per day history of cigarette smoking and occasional alcohol use. The patient denied any illicit drug use and there were no known allergies.

Physical Exam

The vital signs were: temperature 97.8 F, pulse 80, blood pressure 144/100, respiratory rate 18. In general, the patient was a thin, well developed, well nourished male who appeared slightly anxious. The head, eyes, ears, nose, and, throat examination was within normal limits. The neck was supple and without jugular venous distention. The cardiovascular examination revealed a regular rate and rhythm without murmur, rub, or gallop. Pulses were equal and strong bilaterally. The lungs were clear to auscultation and breath sounds were equal bilaterally. The left chest wall was somewhat tender to palpation but the tenderness did not reproduce his chest pain. The abdomen was soft and non-tender with normal bowel sounds. The extremities and neurological examinations were within normal limits.

ED Course

Upon arrival, the patient was placed on oxygen therapy by nasal cannula, and the ECG monitor and

intravenous access was obtained. The initial 12-lead ECG revealed a normal sinus rhythm with a rate of 70, a normal axis, and normal ST-segments and T-waves. There were no old ECG's for comparison. The patient was then given one nitroglycerin tablet sublingually and aspirin 325mg to chew. Blood was drawn for complete blood count, glucose, electrolytes, blood urea nitrogen, creatinine, creatine kinase isoenzymes, troponin-I, and myoglobin. Chest roentgenogram was within normal limits. Arterial blood gases revealed: pH 7.403, pO2 116 mm Hg, pCO2 37 mm Hg, HCO3 23 mmol/l on an FiO2 of 21%. All labs were found to be within normal limits. The patient continued to have pain, although less intense than on arrival, so the ECG was repeated; it was unchanged from the initial recording. A sestamibi scan was then ordered.

Emergency Department Technetium-99M Sestamibi Scans

The use of technetium-99m sestamibi myocardial imaging in the emergency department evaluation of patients with chest pain is a technology that has been slowly evolving over the past several years. Though the development of a number of rapid assays of biochemical markers have proven to be very sensitive and just as specific as enzyme electrophoresis for the early detection of myocardial infarction, there has not been an effective tool to detect those patient with acute coronary ischemic syndromes ACIS [1]. While many patients can clearly be determined to have ischemic pain or infarction, there is still a large number of patients that fall within that gray area in which their disease state is unknown. In the past, emergency physicians have tended to err on the side of caution and admit these patients when in doubt. In a climate of conservation of medical resources this may not be a tenable strategy much longer. National statistics reveal that despite our best efforts there are still 5-8% of patients sent home from the emergency department that will develop an infarction within 48 hours[2]. Emergency technetium-99m sestamibi scans provide a means of developing risk stratification strategies for detecting those patients with ACIS without the necessity of a prolonged hospital admission. An inherently functional test, the sestamibi scan has about a 95% sensitivity for detecting myocardial ischemia and can even be used to predict the risk of a coronary event for the next several months when used properly[3,4,5]. A recent informal poll taken at the Chicago meeting of the National Registry of Myocardial Infarction (attended by the author) revealed that about 30% of the larger medical centers are routinely using sestamibi scans in the evaluation of patients with chest pain. This case report represents the first emergency department sestamibi scan ordered at the University of Mississippi Medical Center and represents a typical patient in which this test would be useful. Though this patient is young and his pain is atypical, he does have several risk factors (male, smoker, family history). The ECG is not helpful in this case since as many as 40 % of all acute myocardial infarctions present with nonspecific tracings. The patient can be said to have a low probability for coronary artery disease and indeed an acute event can be ruled out by serial enzymes for 8-12 hours in the emergency department. However, if the pain represents coronary ischemia that is undetected by enzyme assays then the consequences of missing this diagnosis could result in tragic morbidity or mortality for this young patient. An algorithm for ordering these scans was developed by committee and literature review and is outlined in the schematic. Some key points worth emphasis are:

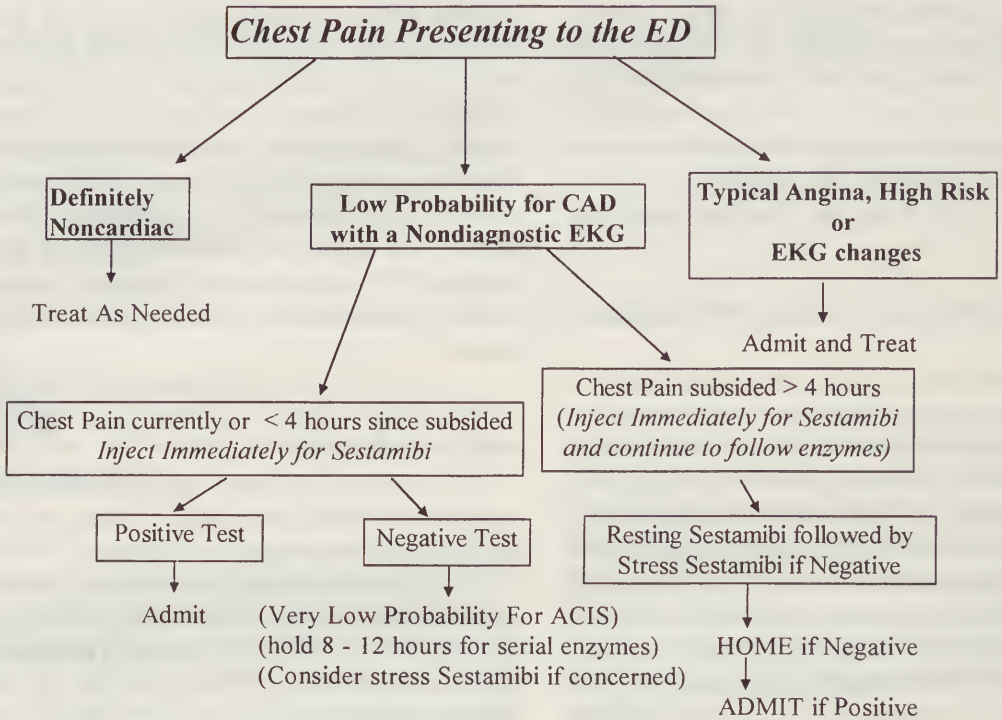
1. This test is only for patients with a low probability of coronary disease (atypical pain, nondiagnostic EKG, 3 risk factors).
2. A resting sestamibi has its greatest sensitivity when injected during an episode of chest pain or within four hours of the termination of the pain.
3. A stress sestamibi scan increases the sensitivity and can be used if the enzymes are negative and if no pain is present. This will allow for overnight vigils and subsequent risk stratification if the scans are not available during the night hours.
4. While the sestamibi scan can detect an infarct, it may require a gated image to determine if the event is acute. Therefore, it is still recommended that serial enzymes be used concomitantly.

Case Report Conclusion

The patient was found to have a negative scan and subsequent biochemical marker studies were also negative. The patient improved symptomatically and was returned home with plans for follow-up. While no strategy can ever be perfect for predicting an acute cardiac event (even catheterization is not 100% sensitive for predicting risks) this represents the most cost effective plan with the lowest risk available today [6]. While it may be difficult for some small center to adopt this strategy, there is enough flexibility in the time frame of this test that the patient can be managed routinely and transferred to a larger center for final evaluation.

General Guidelines for Emergency Technetium-99 Sestamibi Scans

Purpose: For the early, sensitive detection of myocardial ischemia and for risk stratification. Indicated for the low risk, low probability patient with a nondiagnostic EKG and atypical chest pain and whose pain does not have a definite explanation.



Stress Sestamibi only if enzymes are negative for 8 - 12 hours.

Indications - Criteria

1. No previous history of coronary artery disease.
2. Chest that is atypical for angina.
3. Chest pain lasting for longer than 30 minutes.
4. Less than 3 risk factors for coronary artery disease.
5. Normal or nondiagnostic EKG findings.
6. Chest pain is currently ongoing.

   or
7. Can inject isotopes within 4 hours of the onset of chest pain if pain is absent.

Contraindications

1. Patient requires continuous monitoring (cannot go to nuclear medicine).
2. Prior caffeine or theophylline ingestion if the patient is to be stressed.
3. Early pregnancy.

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Oral Magnesium for Tocolysis: A Comparison of Magnesium Gluconate and Enteric-Coated Magnesium Chloride

Rick W. Martin, M.D.
Kenneth G. Perry, Jr., M.D.
James N. Martin, Jr., M.D.
D. Paul Seago, M.D.
William E. Roberts, M.D.
John C. Morrison, M.D

Abstract

Purpose: Following parenteral magnesium tocolysis for patients in preterm labor. The choice of oral tocolytic medications is controversial.

Methods: Over a six-month period, 47 patients who were in preterm labor were randomized after parenteral magnesium tocolysis to receive magnesium gluconate ([Mg-g] 648 mg elemental magnesium/day) or magnesium chloride ([Mg-c] 640 mg elemental magnesium/day). A serum magnesium was obtained 24 hours after the initiation of oral therapy.

Results: In the 25 patients were treated with Mg-g and 22 with Mg-c there were no differences in patient demographics, initial cervical dilatation hours on parenteral magnesium sulfate, recurrent contractions, or side effects between the two groups. The cost was also similar (Mg-c, $1.40/d; Mg-g, $2.11/d). The serum magnesium levels were higher in the Mg-c group (1.80 $\pm$ 0.28 mg/dl) compared to the Mg-g group (1.63 $\pm$ 0.30 mg/dl) but the difference was not significant.

Conclusion: These two preparations of magnesium are similar in their effects on uterine activity and serum levels when used at these dosages.

Key words: Magnesium, Preterm Labor

Introduction

Prematurity complicates 8% of all deliveries in the United States and is responsible for significant infant morbidity and mortality. The parenteral drugs most commonly prescribed for the treatment of preterm labor are magnesium sulfate and the beta-agonists, ritodrine and terbutaline. Although the oral betamimetics are commonly administered for long-term maintenance of uterine quiescence in such patients, the use of magnesium gluconate has also been reported.[1] When magnesium gluconate was compared to beta-agonist, they seemed to be equally effective in promoting continued uterine quiescence in patients recently treated for preterm labor but there were less side effects in the magnesium-treated patients.[2] Nevertheless, one problem noted during this study was that the every four hour dosing pattern limited compliance but reduction in the frequency of administration resulted in a significant decrease in magnesium levels.

The absorption of the various magnesium compounds is related, among other factors, to the amount of elemental magnesium present in the gut. Recently, enteric-coated magnesium chloride (Slow-Mag, GD Searle, Chicago, IL) has become commercially available. This drug is reported to be released in the small intestine, the

site of optimal magnesium absorption. Little information is available, however, concerning the intestinal absorption and effectiveness of these preparations during pregnancy. The purpose of this study was to compare magnesium gluconate and enteric-coated magnesium chloride as oral maintenance agents following parenteral tocolysis for patients with preterm labor.

Materials and Methods

Over a six-month period, 47 patients were studied. The diagnosis of preterm labor was made by the presence of regular uterine contractions with a change in cervical exam. Every patient received magnesium sulfate intravenously; 4 g initially followed by 2 - 4 g/hour parenterally. The infusion was decreased once preterm labor had been successfully arrested. Only patients who responded to parenteral magnesium were candidates for this study. The protocol was approved by the Institutional Review Board and patients gave informed consent prior to participating in the study.

Patients were randomly divided into two groups by use of a random number table. After signing an informed consent form, they received either (a) magnesium gluconate 2 g orally every 4 hours (648 mg elemental magnesium/day; or (b) enteric-coated magnesium chloride 3 tablets then 2 tablets alternately every 6 hours (640 mg elemental magnesium/day). The first dose of oral drug was given concurrently as the intravenous magnesium was discontinued. Each patient was evaluated for gastrointestinal symptoms as well as signs of recurrent preterm labor. A serum magnesium was obtained 24 hours after the initiation of oral therapy. After 48 hours the study was discontinued and all patients were given oral magnesium gluconate 2 g every 4 hours for long-term tocolysis as per our clinical treatment plan. Statistical methods included chi-square and analysis of variance.

Results

Twenty-five patients entered the gluconate group and 22 were in the chloride group. The entry characteristics of each group were similar (Table 1). Patients tolerated both drugs very well as gastrointestinal side effects were not reported in either group. Although the mean serum magnesium level appeared higher in the chloride group (1.80 $\pm$ 0.28 mg/dL) than the gluconate group (1.63 $\pm$ 0.30 mg/dL), the difference was not statistically significant ($p < 0.16$). The number of women experiencing recurrent uterine contraction during the 48-hour observation period was similar in each group (5/25 in the gluconate group and 7/22 in the chloride group; $p < 0.55$).

Discussion

Since the report by Steer and Petrie in 1977 comparing magnesium sulfate and ethanol for the management of preterm labor, magnesium has gained acceptance as a tocolytic drug.[3] Because of adverse gastrointestinal side effects, oral magnesium sulfate is not utilized for maintenance of the ambulatory patient. Most physicians use the oral beta-agonists for continuous uterine quiescence. Unfortunately, beta-agonists drugs are associated with frequent side effects such as palpitations, headache, tremors and nervousness as well as major adverse effects including chest pain, myocardial infarction, and pulmonary edema.[2]

Magnesium has been described as an alternative oral agent for the ambulatory patients with preterm labor. Studies in Europe by Spatling have reported decreases in preterm delivery and admission to the neonatal intensive care unit with the use of oral magnesium supplementation.[4] In this country, Martin et al, studied 50 patients with preterm labor. Magnesium gluconate compared favorably to oral ritodrine with fewer serious side effects reported in the magnesium group.[2] Another magnesium

Table 1. Maternal characteristics

Magnesium preparations	Gluconate (n = 25)	Chloride (n = 22)
Age (yrs)	21.6 $\pm$ 3.7*	22.7 $\pm$ 6.1
Race (Caucasian/African-American)	4/21	6/16
Parity	0.9 $\pm$ 1.1	1.0 $\pm$ 1.0
Gestational age at study entry (wks)	31.2 $\pm$ 3.8	32.1 $\pm$ 3.8
Initial cervical dilatation (cm)	2.0 $\pm$ 1.4	1.9 $\pm$ 1.1
Hours IV magnesium sulfate	12.2 $\pm$ 14.7	10.2 $\pm$ 6.3

*Mean $\pm$ SD

compound, magnesium oxide, was also shown by Ridgway to be as effective as oral terbutaline. Eighty-two percent of the terbutaline group reported side effects compared to 48% with magnesium oxide.[5]

Radiolabelled magnesium (^{28}Mg) studies indicate that maximal absorption occurs within the ileum and jejunum.[6] About 25% to 60% of administered magnesium is absorbed. This process occurs at an equal rate throughout the small intestine. The absorption of magnesium at physiologic doses can be described by a diphasic curve.[6] A linear portion indicates passive diffusion of magnesium across a concentration gradient. Magnesium absorption is also minimally affected by dietary calcium intake, vitamin D, and parathyroid hormone. Certain disease states associated with malabsorption, such as steatorrhea and intestinal by-pass surgery may also affect magnesium absorption.[7] Magnesium is primarily an intracellular cation. The effect of this drug is probably due to its competition with intracellular calcium within the myometrial cell. Although serum levels may not correlate well with clinical efficacy, it is the most widely available method to assess magnesium status.[6] Most clinicians, however, feel if long-term tocolysis is achieved, the serum levels are only valid for avoidance of toxicity.

In the present series, similar magnesium levels were obtained with both magnesium gluconate and enteric-coated magnesium chloride. This supports the concept that the amount of magnesium absorbed is not related to the particular magnesium preparation used nor is affected by the enteric coating of the preparation of magnesium chloride used in this study. In our experience a single dose of magnesium gluconate exceeding 2 g is accompanied by diarrhea or nausea.[2] The larger amount of magnesium in the chloride group (192 mg) was tolerated as well as the lower dose magnesium gluconate. It is possible that the enteric coating diminished the adverse effects of the administered magnesium and improve compliance since it can be taken less frequently. Finally, the cost of the two preparations is similar with Mg-c ($1.40/d) being slightly less expensive than Mg-g ($2.11/d) but both medications much less than terbutaline ($4.20/d) or Ritodrine HCl ($7.84/d).

In conclusion, magnesium gluconate and enteric-coated magnesium chloride achieved equal serum levels of magnesium. Because a larger single dose of magnesium was given in the chloride group, the dosing interval may have beneficial effects upon patient compliance for the chloride group. Further study is necessary to confirm this hypothesis.

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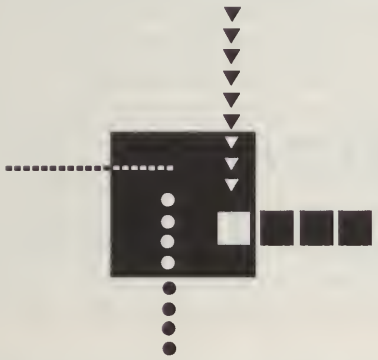
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Physicians dedicated to the health of America

Meet 1998-99 MSMA President Michael H. Carter, Jr., M.D.

It is with a strong sense of good fortune that the Mississippi State Medical Association greets the inauguration of Michael Hammond Carter, Jr., M.D. With a full agenda ahead, this vigorous association welcomes an outstanding leader, with his capabilities, accomplishments and unflagging devotion to organized medicine.

A glimpse at Dr. Carter's membership file will quickly tell you he is an otolaryngologist practicing in Greenwood, Mississippi, that he is active in his specialty societies and vocal on issues pertaining to MSMA membership. There is a far more interesting side of Dr. Carter you will find though...if you ask.

Where did you grow up? Tell me about your upbringing.

My home town is Greenwood. I went entirely through school in Greenwood from first grade until graduation in 1961. In high school I was not the very top student, but I was in the top part of the class. I was a three year letterman in football at Greenwood High, where we had some outstanding teams, winning the Big 8 conference championship one or two of those years. I was the starting center for two years. In 1960, the summer after my junior year in high school, I attended American Legion Boy's State, and was extremely lucky to be elected one of Mississippi's two participants in Boy's Nation in Washington, D.C. My experience at Boy's Nation was truly an epiphany for me, especially opening my eyes with regard to racial matters. Looking back, my naivete as an adolescent in Mississippi in those years seems amazing and bizarre. At Boy's Nation, for the first time, I encountered a number of black youths my age who were at least as smart as, and in most cases, more sophisticated than myself. My realization was undeniable and it made a profound and permanent change in my attitude in racial matters. It was a real turning point in my mind set, which I recognized very well at the time and have always remembered.

Though my initial plan had been to attend Davidson College in North Carolina, the unexpected offer of a Carrier Scholarship drew me to Ole Miss. I enjoyed a wonderful four years in Oxford where I majored in English, minored in French and Biology, and was very active in Phi Delta Theta fraternity and several campus organizations.

My father paid my college expenses and allowed me to keep the Carrier Scholarship money, which I saved until graduation in 1965. At that point I bought a round trip airline ticket to Paris, picked up a BMW motorcycle in Munich, and enjoyed an ecstatic summer of travel all over Europe, a fabulous adventure.

So, when and where did you go to medical school?

That fall I entered medical school at Tulane, and by the end of the first semester I realized that I should have taken more biology and chemistry in college. After an academic struggle the first year, things eventually smoothed out during the remainder of four years at Tulane, and I graduated in the top half of my class.

How did you meet your wife, Mary Rose?

Midway through medical school, Mary Rose and I began courting, and we married just before my senior year. Mary Rose was a Delta Airline stewardess when we began courting. Shortly she began a series of career changes, working next as a school teacher, then as a welfare worker in New Orleans, and finally as a medical photographer at Tulane. This was the beginning of her long and pleasurable career as a professional photographer. She has earned academic degrees in this field as well as accruing skills in more and more types of photography, especially children's portraits and architectural images, which she contributes regularly to *Mississippi* magazine.

Her father was a physician, wasn't he?

Mary Rose was the daughter of Dr. and Mrs. Lynn D. Abernethy in Jackson. Dr. Abernethy was one of the first, perhaps the very first, certified ophthalmologists in Jackson, and an active member of MSMA. To know him well was a pure pleasure.

What were your Tulane years like?

After graduating from "med school" we were very fortunate to be able to stay in New Orleans through the outstanding residency program in Otolaryngology-Head and Neck Surgery. A number of my fellow residents at Tulane were truly talented, and we continue to be close friends.

Our children, Claire and Walker, were born in New Orleans.

What did you do after you finished your residency?

Upon completing the residency in 1974, our little family (Claire was 4, Walker 1) entered the U.S. Air Force, assigned to the European referral hospital in Wiesbaden, West Germany. As I recall my three years in the Air Force, I simply cannot remember any unpleasurable parts. There must have been some things that were disagreeable, but I honestly cannot remember what they were. In retrospect, it seems like a three year paid vacation. The professional work was great. Two seasoned mentors in the ENT department were in place and fantastic friendships developed. Travel opportunities seemed boundless. Though we cannot get together very often, friendships with a number of our German friends continue.

When did you establish your practice in Greenwood? Tell me about your practice.

In 1977 we moved back home to Greenwood, rented an apartment, made a big loan, and established

MICHAEL H. CARTER, JR., M.D.

Born: *March 30, 1943; Jackson, Mississippi.*

Education:

• *University of Mississippi; B.A. English.* **Social Fraternity:** *Phi Delta Theta (several offices, including President).*
Honorary Fraternities: *ODK, Phi Eta Sigma.*
Carrier Scholarship.

• *Tulane University Medical School: M. D. 1969.*
Internship *(surgery): 1969-70.*
Residency; *Otolaryngology, Head and Neck Surgery: 1970-74 (Charity Hospital, New Orleans; Eye, Ear, Nose and Throat Hospital, Ochsner Foundation Hospital).*

Professional:

Private Practice: *Carter and Lambdin, P. A., Greenwood, Mississippi, 1977-present. All areas of Otolaryngology-Head and Neck Surgery, including facial plastic and reconstructive surgery.*

Hospital Staff Memberships:

• *Greenwood Leflore Hospital, active medical staff (several offices, including Chief of Medical Staff, liaison member of hospital board).*
• *University of Mississippi Medical Center, visiting attending, clinical instructor in Otolaryngology - Head and Neck Surgery.*

Professional societies:

• *Delta Medical Society.*
• *Mississippi State Medical Association (former Chairman of the Board of Trustees).*
• *American Medical Association (Alternate Delegate from MSMA).*
• *Mississippi Physicians Care Network, Vice President.*
• *American Academy of Otolaryngology Head-and-Neck Surgery (Fellow).*
• *American Academy of Facial Plastic and Reconstructive Surgery (Fellow).*
• *American College of Surgeons (Fellow).*
• *Mississippi Eye, Ear, Nose and Throat Association (former President)*
• *Louisiana-Mississippi Eye, Ear, Nose and Throat Association.*

Church: *Episcopal Church of the Nativity, Greenwood (former vestry member).*

Civic:

• *Former Rotary Club member.*
• *A+ for Greenwood (founding Board member).*
• *Greenwood-Leflore-Carroll Economic Development Foundation (former Board member).*
• *Greenwood-Leflore Chamber of Commerce (former Board member).*
• *Greenwood Community and Recreation Center (former Board member).*

Other: *Trustmark National Bank Advisory Board member, 1980 to present.*

a solo otolaryngology practice. Long before I could afford it, I was determined to have a partner. It was a great development, in 1979, when I met and successfully recruited Jeff Lambdin to join me in practice. We established a very steady, extremely satisfying partnership and friendship. Our personalities probably are more dissimilar than similar and complementary in many ways. We respect each other greatly and support each other in our varied interests. The prime example of this relationship is the fact that Jeff is not drawn to participate much personally in organized medicine, yet without his constant support, I could not have participated as actively as I have in this area which I deem to be so important for our profession.

So, from Greenwood you came and to Greenwood you returned. Are your parents still living? There?

My parents, Mike and Lucy Carter, continue to live in the home in Greenwood where my two younger brothers and I grew up. My father retired a few years ago after a 40 year career as general manager of a large, multifaceted farm supply cooperative. My mother is a housewife and mother *nonpareil,* of the old school.

Where do your children live now? What do they do?

My daughter Claire Noelke practices law as a prosecuting attorney in San Angelo, Texas. My son Walker has recently launched a career as a consultant analyst in Princeton, New Jersey at the principal U. S. Office of PA Consultants, a British-based international consulting firm specializing in telecommunications and health care related industries.

When and why did you get involved in MSMA?

I joined MSMA when I received my Mississippi medical license. In recent years we have seen changes in the "economic" side of medicine. There are looming proposals for even more disturbing changes. There are continual attempts by various "quasi-medical" groups to usurp certain areas of medical practice. There are often times strained interactions with the insurance industry. It behooves all of us to be attentive and responsive to all these issues in an attempt to maintain and improve the quality of health care in our state. The Mississippi State Medical Association is an outstanding and effective organization which enables us as practitioners in Mississippi to participate in this ever-changing process. It is essential that we maintain a broad-based support for and participation in this organization among Mississippi physicians.

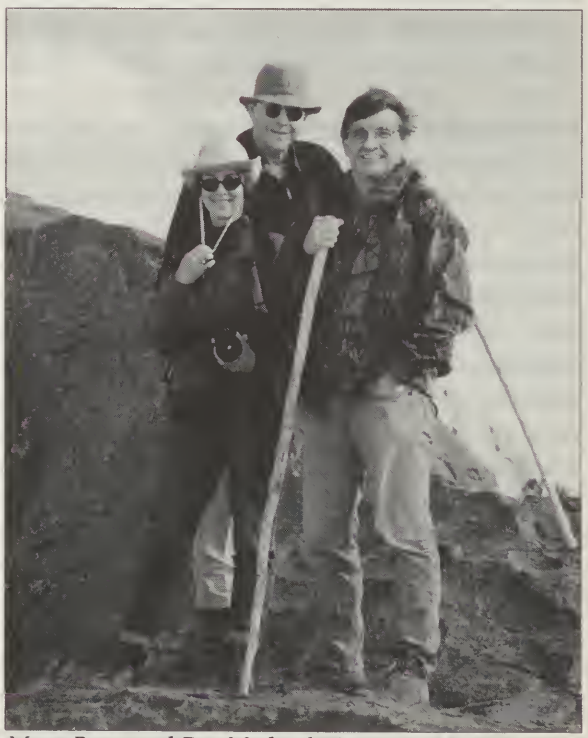
I feel myself to be the most fortunate of people, to



Walker, Mary Rose, Claire and Dr. Michael H. Carter, Jr. at Claire's wedding.



Walker and Dr. Michael H. Carter, Jr. on a Colorado motorcycle trip.



Mary Rose and Dr. Michael H. Carter, Jr. with their friend, Joe Donaldson, at Big Bend.

be able to practice medicine along side the outstanding physicians in Mississippi, and to have the opportunity to participate extensively in an organization such as the Mississippi State Medical Association. This is both a great privilege and a very special honor.

As I have engaged personally more and more with MSMA, I continue to be impressed with the competence and commitment of our staff as they carry out the very important work of this association.

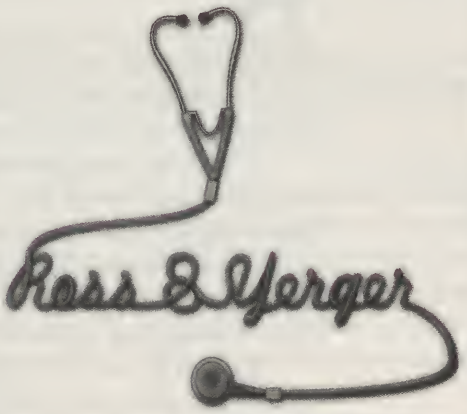
While MSMA membership numbers remain on the increase, some physicians complain about Mississippi being a unified state with the AMA. What would you tell those physicians?

During my term as Chairman of the Board of Trustees, the association visited again the question of whether to continue the linkage of membership between MSMA and AMA. I was proud when the informed vote of the House of Delegates in 1997 was overwhelmingly favorable to maintaining this close connection. In terms of monitoring developments in our rapidly changing health care environment, communicating issues to members, etc., there is simply no effective substitute for the AMA. The unification of MSMA and AMA affirms an important coherence of our organizations, allowing the profession to operate effectively, influence policy development and respond to challenges which arise from both the state and national level. I can site several examples of resolutions which arose from the Delta Medical Society, proceeded through the MSMA and the AMA House of Delegates, and led to important actions on the part of the AMA. These actions had important effects in the congressional arena, especially in the regulatory bureaucracy both in Washington, D.C. and in various states. These organizations are very accessible to their members, and there are many examples of meaningful action resulting from ideas generated by individual members.

Is there anything else you would like for members to know about yourself that I have not asked you?

This is it. This is me. This is whom you have elected President of your association for the upcoming year. I promise my best efforts in this job. With your support, I am confident that this will be another good year for MSMA.

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Michael H. Carter, Jr., M.D.

The President's Page

"Bon Voyage!"

Blue skies. Calm seas. Big fish. These are the things I wish for Charlie Mathews. MSMA's Executive Director, for nearly 27 years, Charlie is retiring this month. The association's 1998 Annual Session will be his last at the helm. And, although I'm saddened to see him leave I am comforted to see that my friend is excited about beginning this new chapter in his life.

Charlie did not start out to be a medical association executive. No, he started out to be a newspaper man. Fresh from Louisiana State University with a bachelors degree in journalism, Charlie had ink in his veins just like his father, a respected newspaper publisher. I don't know what steered him away from his original plan; but, I'm glad it did. I'm glad that Charlie first came to the Mississippi State Medical Association as our Associate Executive Secretary in 1960 and that he chose to return later as MSMA's Executive Director.

He took a couple of curious "breaks in service," like the time he left MSMA in the 1960s to spend two years as the Deputy Director of the Mississippi Medicaid Commission; then he hopped out of that frying pan and into the fire to serve the State as its Commissioner of Welfare until 1972. When he returned to MSMA, Charlie brought an insight into government programs that for the past 26 years has been of great benefit to MSMA and our members.

Most of us know Charlie as a great guy with a bright smile and a hearty laugh that simply begs you to join in on the fun. We know him as an animated prankster who so naturally makes others laugh. Many of us know Charlie from the myriad AMA projects to which he contributed or his impact on Southern Medical Association programs. Any attempted list of his contributions would be an understatement. He is so much more.

Charlie wasn't born in Mississippi, but he got here as quickly as he could. Originally from Maryland, where he met his beloved wife, Phoebe, their roots grew deep in Mississippi soil. He reared his family here and his daughter, Lacey, and sons, John and Charlie, Jr., are testaments to his loving guidance.

Charlie has dedicated a three-decade career to the advancement of organized medicine. He has guided the association through the quagmires of Medicaid and managed care. He has helped us build a sturdy House of Delegates. And he's leaving MSMA now to build a new bond with the sea. You see, Charlie has always been a fisherman. When others played golf, Charlie fished. When others dreamed of trophy bucks, Charlie dreamed of setting sail.

Now, as he embarks on his next adventure, we shall say a fond farewell to a valued friend with a smile and a hearty, "Bon Voyage!"

Mike Carter

Editorial

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MISSISSIPPI STATE MEDICAL ASSOCIATION
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Navigating the New E & M Requirements-Sailing Troubling Waters

In September, 1997, United Healthcare, in it's *MEDICARE PROVIDER NEWS* published the new documentation guidelines for E & M services. As originally intended these guidelines were to become effective October 1, 1997, with a grace period from that date to December 31, 1997. The grace period was then extended until July 1, 1998, after which time providers must use the 1997 guidelines for all submissions for payment. Currently the AMA is negotiating for a further extension of the grace period. This is in response to a grass roots reaction by the general membership to the proposed changes. There is much concern about the interpretation of the fraud and abuse possibilities, especially as related to inadvertent coding and documentation errors. It has been stated that "if providers would follow the published guidelines they would not have any problems." Therein is the problem. There are many areas subject to interpretation, and therefore many potential conflicts. It is the interpretation of these areas that greatly concerns physicians.

The original E & M guidelines were developed jointly by HCFA and the AMA and attempted to establish standards of consistency in clinical descriptors and definitions, and would be acceptable to clinicians while at the same time minimize record keeping, and would be applied and interpreted uniformly across the country.

The 1997 E & M changes have greatly expanded the original guidelines and now define the content of a general multisystem examination, changed documentation requirements for such examinations, and outlined documentation requirements pertaining to ten specific organ systems in addition to the general multisystem examination. Several other changes outline four types of examination: problem focused, expanded problem focused, detailed and comprehensive. These new E & M guidelines are being instituted to assure that medical records reflect the pertinent facts, findings, and observations as related to a patient's medical history. They further define specific areas, that when addressed, will fulfill these requirements. The general principles of medical records documentation is outlined, and such documentation is expected for each patient encounter, regardless of the place of service.

The three key components of documentation are: history, physical examination , and medical decision making. Four additional components may come into play in establishing the level of service in any patient encounter, these are: counseling, coordination of care, nature of the problem, and time.

Next, physicians are expected to document the complexity of medical decision making with specific levels outlined: straight forward, low complexity, moderate complexity, and high complexity. This data is arrived at by considering the number of diagnoses or management options, complexity of pertinent data reviewed, and the risk of complications, morbidity and/or mortality.

As you have probably recognized this is beginning to look like some type of documentation, or order form, for purchasing parts or equipment for one of the Pentagon occupants. Everything is expected to be interpreted in a very straight forward manner, given a specific order number, and the order fulfilled. As all of us in medicine know, things are not that simple. There are too many gray areas and variations in illnesses and patients to be so straight forward as in this new system. It is also intriguing to note that mistakes and errors in the new E & M system is punishable as fraud while the purchase of seven hundred and fifty dollar toilet seats, or hammers costing several hundreds dollars, when purchased through the Pentagon services is not subjected to the same punishment threats.

Yes, the new E & M documentation guidelines are a real maze and if not changed will prove extremely difficult to navigate. This is particularly true when one is not sure how to interpret the maps and beacons while trying to avoid storms.

-Myron Lockey, M.D.
Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

Health Care Financing Administration Awards Special Project to FMC

Mississippi has the fifth highest Medicare readmission rate in the nation with 2.29 percent readmitted within two days, 11.3 percent readmitted within 15 days and 18.19 percent readmitted within 30 days in calendar year 1995. Mississippi's top DRGs also show high readmission rates. The Foundation's 1998-1999 Short-Term Hospital Readmission Program Integrity Project, to be conducted under a grant from the Health Care Financing Administration, will include a comprehensive analysis and evaluation of readmission rates and chart review of clinical performance indicators and utilization practices. The period of performance for completion of all required efforts will be April 1998 through March 31, 1999.

The Foundation developed readmission profiles for calendar year 1996 and January 1, 1997, through July 31, 1997. These profiles and summary tables will include readmission frequencies, rates per 100, average length of stay, average charges and average reimbursement. The profiles will be analyzed by DRG, Provider and Provider/DRG. Separate analytic files have also been developed containing individual paired readmissions for further in-depth analysis and sample selection.

Analysis of readmission rates by 2, 15 and 30 days show the majority of the readmissions are between 3 and 15 days with the next highest percentage between 16 and 30 days. Readmission patterns for 15 days and 30 days by DRG and provider show similar patterns. Different patterns are seen for the two-day readmissions. Also, because of the high number of Mississippi Medicare beneficiaries with chronic illnesses, readmissions at 30 days are more likely to be unavoidable. For these reasons, the Foundation proposes further evaluation of 2 and 15 day readmissions.

The analysis will be limited to readmissions within the same hospital and will eliminate transfers coded in error and focus on cases in which there may be more of a financial incentive for readmissions. The focus on same-hospital readmissions will offer the greatest opportunity for improving readmission rates.

Further analysis of patterns will be performed by overall volume and distribution of readmissions as well as analysis for specific patterns related to inappropriate "staging" of admissions, intervening stays in PPS exempt units and quality of care concerns. Analysis of contributing factors for providers and DRGs with high rates will include: original and readmitting DRG, subacute stays between readmissions, length of stay, attending physician, discharge destination and charges and reimbursement.

With clinical input from Foundation physician consultants, the patterns with the most potential for program integrity and quality of care concerns will be selected for review. Approximately 750 pairs of 1,500 cases will be reviewed and classified in the categories of appropriate and unavoidable; avoidable with improved quality of care; or inappropriate readmissions.

Following data analysis, a Readmission Analysis Summary Report will be submitted to HCFA.

When utilization/program integrity concerns are identified, denials will not be issued, but improvement projects and/or feedback of findings will be implemented.

For more information on this project, contact Dr. James S. McIlwain at 601-354-0304.

The analyses upon which this publication is based were performed under Contract Number 500-96-P510, entitled, "Utilization and Quality Control Peer Review Organization for the State of Mississippi," sponsored by the Health Care Financing Administration (HCFA), Department of Health and Human Services. The content of this publication does not necessarily reflect the views or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government. The author assumes full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care Quality Improvement Program initiated by HCFA, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore, required no special funding on the part of this Contractor. Ideas and contributions to the author concerning experience in engaging with issues presented are welcome.



Smoking Prevention/Cessation Survey

A survey of health care providers concerning current smoking prevention/cessation therapies is discussed by Dr. Ed Thompson, State Health Officer, seated, Dr. James McIlwain, FMC president, Ellen Jones, director of Tobacco Policy and Prevention, State Department of Health, and Barbara Guy, FMC contract specialist.

News of Note—

The Mississippi State Department of Health and the Foundation for Medical Care have released a survey to collect information on current tobacco prevention/cessation practices of Mississippi physicians and other health care practitioners. Barriers which make it difficult for physicians to provide tobacco prevention/cessation counseling and support to their patients will also be identified.

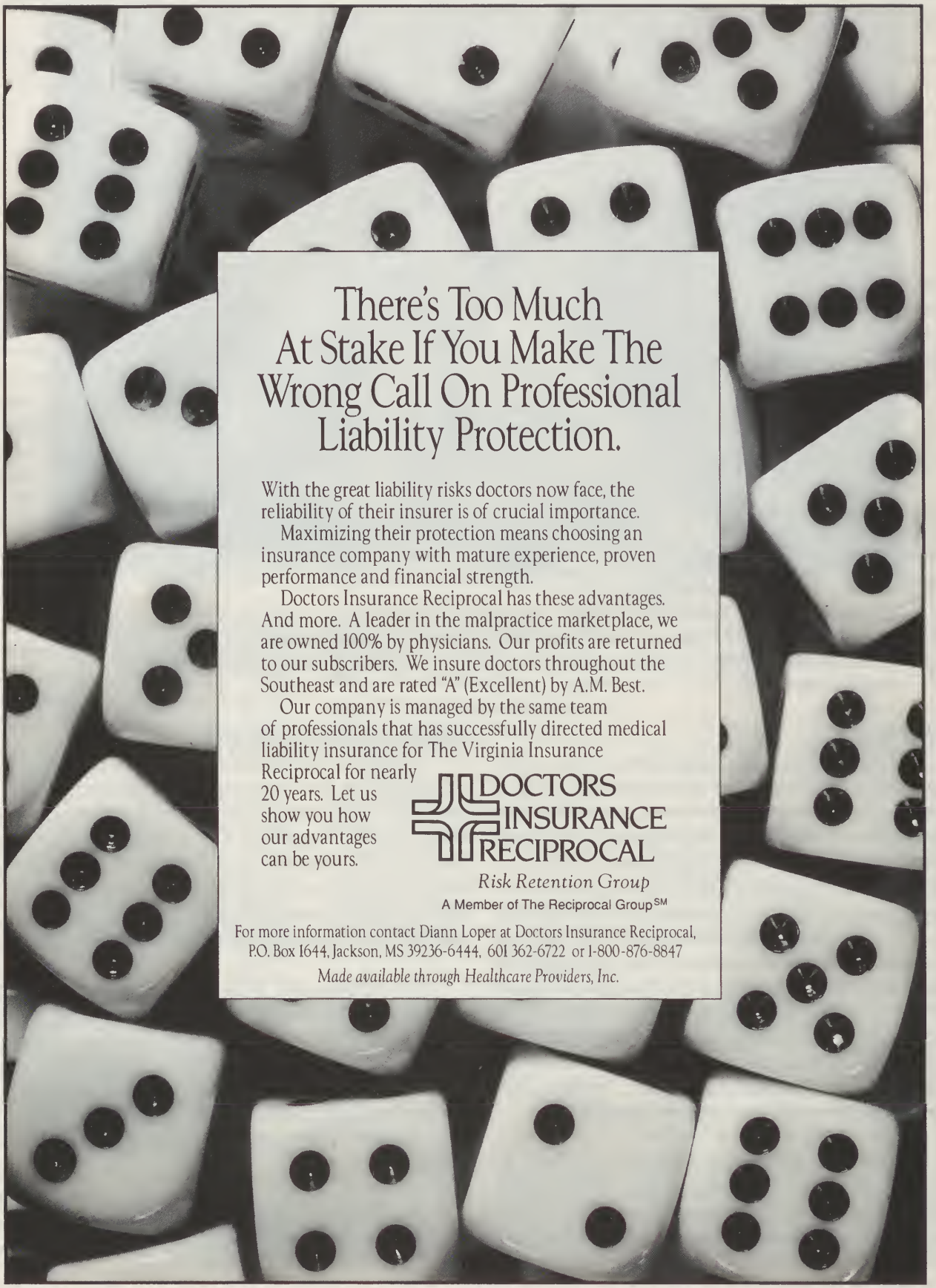
The information collected will help establish baselines to measure the success of future tobacco prevention projects such as those funded with tobacco settlement monies. It will also identify barriers which can be addressed in these projects. Obtaining this information is a vital part in the ongoing fight against tobacco and tobacco related illnesses in the state. All physicians receiving a survey are encouraged to respond.

•Interested physicians are sought for work with the Foundation's review program. Board certification is preferred, and a Mississippi license is required. Previous experience may mean extra benefits, and certification is offered (CPUR by InterQual). Contracted service is available from home, office or onsite.

•Staff is now available to assist in providing a clinical service, that of participating in the reverification process of PPS-excluded units or providing neutral, nonbiased review consultation with specific recommendations for quality improvement. The Geriatric-Psychiatric Quality Service Review promotes excellence in utilization management, maintenance of licensure/accreditation standards and documentation for Medicare compliance.

•The Foundation is also offering several coding services in the areas of ICD-9-CM, CPT, DRG and APG preparation. Included in the services are on-site coding training and education; coding audits—validation review of code assignments, inpatient and outpatient; consultation on compliance plans; coding seminars; DRG training; E& M audits of physician office records, and backlog coding.

For further information concerning these items, contact Dr. James S. McIlwain or Dr. Denise Auttonberry at the Foundation, 601-354-0304.



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MSMA Alliance Presents Health Choice '98



JeVon Thompson keeps children on the edge of their seats with his motivational presentations like this one held in Natchez.

Health Choice '98 took place the week of March 23 through 27. In its eighth year, Health Choice once again brought motivational speaker JeVon Thompson to Mississippi for workshops with children around the state. Through the years, thousands of students in Hattiesburg, Jackson, Columbus, Laurel, Pascagoula, Tupelo and Gulfport have benefited from these workshops. A new city, Natchez, was included this year as JeVon traveled about the state giving 90 minute presentations. Educators throughout the state have voiced their appreciation for these workshops which focus on drug abuse, tobacco use, violence and other negative behaviors while teaching goal-setting, conflict resolution and self-reliance.

New Members

ALMAND, JEFF D., Greenville. Born Eustis, FL, February 3, 1965; MD Tulane University School of Medicine, New Orleans, LA, 1991; orthopedic surgery residency, Duke University, Durham, NC, 1993-97; elected by Delta Medical Society.

ANG, CESAR K., Clinton. Born Philippines, August 8, 1962; MD Far Eastern University Medical School, Philippines, 1986; internal medicine residency, St. Luke's Medical Center, Cleveland, OH, 1991-94; elected by Central Medical Society.

BLACKLEDGE, THOMAS R., Indianola. Born Vicksburg, MS, January 29, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1994; family practice residency, University of Alabama Medical Center, Tuscaloosa, AL, 1994-97; elected by Delta Medical Society.

BROUSSARD, CURTIS A., Gulfport. Born Lafayette, LA, August 23, 1954; MD Louisiana State University School of Medicine, Shreveport, LA, 1975; one year internship, same; elected by Coast Counties Medical Society.

BUCKLEY,ROBERT, Tupelo. Born Starkville, MS, February 24, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1990; general surgery residency, University of MS Medical Center, Jackson, MS, 1990-95; plastic surgery residency, University of Tennessee College of Medicine, Chattanooga, TN, 1995-97; hand surgery fellowship, University Medical Society, Jackson, MS, 1997-98; elected by Northeast MS Medical Society.

BUCKLEY, STEPHEN EARLY, Hattiesburg. Born Pascagoula, MS, July 6, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1990; interned, one year, University of Miami Medical Center, Miami, FL; internal medicine residency, University of South Alabama Medical Center, Mobile, AL, 1991-94; gastroenterology fellowship, Same, 1994-97; elected by South MS Medical Society.

CLARK, WILLIAM GRAY, Laurel. Born Winona, MS, April 24, 1943; MD Rush Medical College, Chicago, IL, 1976; interned, one year St. Joseph's Hospital & Medical Center; psychiatry residency, E. Carolina University, 1981-82; Maricope Medical Center, 1983-85, and Southern Illinois School of Medicine, IL 1/86-9/87; elected by South MS Medical Society.

COPELAND, DEBORAH, Oxford. Born Picayune, MS, February 23, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1993; interned, one year, University of Louisville, KY, 1993-94; family medicine residency, same, 1994-96; elected by North MS Medical Society.

DESHAZO, RICHARD D., Jackson. Born Birmingham, AL, April 4, 1945; MD University of Alabama School of Medicine, Birmingham, AL, 1971 and interned one year; Allergy/Immunology residency Walter Reed Army Medical Center, Washington, DC, 1972-77; elected by Central Medical Society.

DONATI, DONNA LOUISE, Pascagoula. Born Memphis, TN, July 27, 1963; MD University of Tennessee School of Medicine, Memphis, TN, 1990; radiology residency, University of South Alabama Medical Center, Mobile, AL, 1992-97; elected by Singing River Medical Society.

EIFERT, BRIAN E., Meridian. Born Belle Glade, FL, April 26, 1961; MD University of Mississippi School of Medicine, Jackson, MS, 1988; internal medicine residency, Greenville Hospital Systems, Greenville, South Carolina, 1988-91; diagnostic residency, University of Mississippi School Medical Center, MS, 1991-93; elected by East MS Medical Society.

FRIEDMAN, RICHARD B., Jackson. Born Queens, NY, January 18, 1954; MD Medical College of Virginia, Richmond, VA, 1993; internal medicine internship, one year, Same; Radiation Oncology residency, Same, 1994-97; elected by Central Medical Society.

GENTRY, JERRY LEE, Robinsonville. Born Louisville, MS, May 31, 1963; MD Howard University College of Medicine, Washington, DC, 1988; surgical internship, NNMC, Bethesda, MD, one year; general surgery residency, Naval Hospital, Oakland, CA 1991-94; elected by Clarksdale & Six Counties Medical Society.

HAJJAR, JOSEPH DANIEL, Meridian. Born Columbia, SC, July 28, 1966; MD University of Florida School of Medicine, Gainesville, FL, 1992; radiology residency University of Texas, Southwestern,

Dallas, TX, 1992-96; MRI & Body Imaging Fellowship, Same, 1996-97; elected by East MS Medical Society.

HALLQUIST, ROBERTA R., Greenville. Born Saint Cloud, MN, January 26, 1955; MD University of Minnesota Medical School, Minneapolis, MN, 1980; medicine residency, North Carolina Baptist Hospital, Winston-Salem, NC 1980-83 and University of; neurology residency, University of Iowa Hospitals & Clinics, Iowa City, IA 1983-84; elected by Delta Medical Society.

HERMINGHUYSEN, DAVID COLLIN, Hattiesburg. Born Shreveport, LA, April 15, 1958; MD Louisiana State University School of Medicine, Shreveport, LA, 1985; internal medicine residency, LSU Medical Center, New Orleans, LA, 1985-88; endocrinology fellowship, Same, 1992-93; elected by South MS Medical Society.

HERRON, IRMA LOUREE, Jackson. Born Rolling Fork, MS, December 25, 1960; MD University of Mississippi School of Medicine, Jackson, MS, 1986; family practice residency, University Medical Center, Jackson, MS, 1986-89; elected by Central Medical Society.

KALATHOOR, SUNEETHA, Jackson. Born India, March 8, 1965; MD Medical College of Georgia, Augusta, GA, 1991; internal medicine residency, Bowman Gray School of Medicine, Winston-Salem , NC, 1992-95; infectious disease fellowship, same, 1995-97; elected by Central Medical Society.

KAUFMANN, SILVIA, Centreville. Born Mexico City, Mexico, April 224, 1952; MD National Autonomous University of Mexico, 1975; internship, one year, University of Texas Medical Center, Houston, TX; pediatric residency, University of Minnesota Medical Center, Minneapolis, MN, 1993-95; elected by Amite-Wilkinson Medical Society.

KEMP, STEPHEN F., Jackson. Born Richmond, VA, December 30, 1960; MD Medical College of Virginia, Richmond, VA, 1990; internal medicine residency, University of Tennessee Medical Center, Memphis, TN, 1990-93; allergy & immunology fellowship, University of South Florida, Tampa, FL, 1993-95; clinical, Lab, Immunology, fellowship, Same, 1995-96; elected by Central Medical Society.

KOSEK, MARY ANNE, Jackson. Born Detroit, MI, October 15, 1954; MD Michigan State University College of Human Medicine, East Lansing, MI, 1985; pediatric residency, Rainbow Babies Hospital, Cleveland, OH, 1985-1988; neonatology fellowship, Same, 1988-91; elected by Central Medical Society.

KOWALEWSKI, DONALD CHARLES, Gulfport. Born New Jersey, October 23, 1959; DO Michigan State University College of Osteopathic Medicine, East Lansing, MI, 1987; internship, one year, Pontiac Osteopathic Hospital, Pontiac, MI, 1987-88; internal medicine residency, Same, 1988-90; critical care fellowship, Detroit Medical Center, Detroit, MI, 1990-92; elected by Coast Counties Medical Society.

LEHMAN, THOMAS M., Wiggins. Born Ohio, March 1, 1956; MD University of Cincinnati College of Medicine, Cincinnati, OH, 1983; internal medicine residency, Same, 1983-86; cardiovascular disease fellowship, Same, 1986-88; elected by South MS Medical Society.

MILLETTE, THEODORE M., Pascagoula. Born Pascagoula, MS; MD University of Mississippi School of Medicine, Jackson, MS, 1980; pediatric residency, University Medical Center, Jackson, MS, 1980-83; elected by Singing River Medical Society.

MOORE, KENNETH LAWRENCE, Jackson. Born Jacksonville, FL, September 24, 1948; MD University of Chicago College of Medicine, Chicago, IL, 1975; internal medicine & neurology residency, Rush-Presbyterian, Chicago, IL, 1975-81; elected by Central Medical Society.

MORGAN, MICHAEL MORRILL, Jackson. Born Greenwood, MS, June 26, 1962; MD University of Mississippi School of Medicine, Jackson, MS, 1994; internal medicine residency, University Medical Center, Jackson, MS, 1994-97; elected by Central Medical Society.

PERRY, GLORIA MANGUM, Jackson. Born Jackson, MS, December 14, 1961; MD Howard University College of Medicine, Washington, DC, 1986; family practice residency, Howard University Hospital, Washington, DC, 1986-89; elected by Central Medical Society.

PICKERING, BILLY MACK, Seminary. Born Collins, MS, November 15, 1959; MD University of Mississippi School of Medicine, Jackson, MS, 1985; family practice residency, Tuscaloosa Family Practice Program, Tuscaloosa, AL, 1985-88; elected by South MS Medical Society.

RAMADAN, FAUD, Pascagoula. Born Lebanon, April 15, 1959; MD American University of Beruit, Beruit, Lebanon, 1983; general surgery residency, University of North Carolina Medical Center, Chapel Hill, NC, 1983-89; vascular surgery fellowship, same, 1993-94; elected by Singing River Medical Society.

RIAD, ASHRAF, McComb. Born Egypt, July 14, 1967; MD Jefferson Medical Coolege of Thomas Jefferson University, Philadelphia, PA, 1992; interned one year, Chestnut Hill Hospital; anesthesiology residency, Tulane Medical Center, New Orleans, LA, 199-96; elected by South Central Medical Society.

SMITH, DAVID PERRY, McComb. Born McComb, MS, August 27, 1968; MD University of Mississippi School of Medicine, Jackson, MS, 1994; family medicine residency, University Medical Center, Jackson, MS, 1994-97; elected by South Central Medical Society.

STANLEY, GARY E., Jackson. Born Lake Providence, LA, October 15, 1964; MD Lousiana State University School of Medicine, Shreveport, LA, 1993; pediatric residency, LSU Medical Center, Shreveport, LA, 1993-96; elected by Central Medical Society.

STOKLEY, CHARLES TODD, Waynesbobo. Born Columbus, GA, February 4, 1968; MD University of Mississippi School of Medicine, Jackson, MS, 1994; family medicine residency, University Medical Center, Jackson, MS, 1994-97; elected by South MS Medical Society.

THAGGARD, MICHAEL STACY, Meridian. Born Laurel, MS, January 27, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1990; radiology residency, University of Texas, Southwestern Medical Center, Dallas, TX, 1990-94; elected by East MS Medical Society.

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THOMAS, MITCHELL A., Meridian. Born Ruleville, MS, January 27, 1953; MD University of Mississippi School of Medicine, Jackson, MS, 1978; radiology residency, University Medical School, Jackson, MS, 1978-82; elected by East MS Medical Society.

TIBBS, ELIZABETH McARTHUR, Cleveland. Born Tuscaloosa, AL, May 14, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1992; pediatric residency, University Medical Center, Jackson, MS, 1992-95; elected by Delta Medical Society.

TRIEU, THOMAS T., Biloxi. Born Vietnam, February 7, 1967; DO University of Health Sciences College of Osteopathic Medicine, Kansas City, MO, 1994; family medicine residency, University of Arkansas Medical Center, Ft. Smith, AR, 1994-97; elected by Coast Counties Medical Society.

WALSH, PENNY J., Amory. Born July 31, 1968; MD University of Texas Medical School, San Antonio, TX, 1994; pediatric residency, Medical College of Virginia Medical Center, Richmond, VA, 1994-97; elected by Northeast Medical Society.

WIERZBICKA, GRAZYNA, Pascagoula. Born October 23, 1956; MD Akademia Medyczna (Medical Academy) 1981; pediatric residency, University of South Alabama Medical Center, Mobile, AL, 1992-94; elected by Singing River Medical Society.

WILLIAMS, AARON O., Greenwood. Born Griffin, GA, November 10, 1962; MD University of South Florida Medical School, Tampa, FL, 1993; interned one year, Providence Hospital, Southfield, MI; radiation oncology.

DEATHS

JOHN W EVANS, SR., Jackson. Born August 22, 1914; MD University of Tennessee College of Medicine, Memphis, TN, 1942; interned one year, Gorgas Hospital, Ancon, Canal Zone; radiology residency, John Gaston Hospital, Memphis, TN, 1946-49; died February 19, 1998, age 83.

GRAVES, SIDNEY O., JR, Natchez. Born Laurel, MS, Nov. 30, 1920; MD University of Tennessee College of Medicine, Memphis, TN, 1944; interned one year Jefferson Davis Hospital, Houston, TX; surgery residency, Carraway Methodist Hosp., Birminghan, AL, 1947-52; died 2/23/98, age 77.

NETTERVILLE, RUSH E., Jackson. Born August 1913; MD Louisiana State University School od Medicine, New Orleans, LA, 1940; interned one year, Charity Hospital of LA, New Orleans; surgery residency Huey P. Long Charity Hospital, Pinevillie, LA, 1940-41, Baltimore City Hospital, Baltimore, MD, 1/46 - 6/49; died March 30, 1998 age 84.

PARKS, LEON C., Union. Born September 15, 1939; MD University of Colorado School of Medicine, Denver, CO, 1966; interned one year, John Hopkins Hospital, Baltimore, MD; surgery residency, same, 1967-68, 70-71,73-76; cardiovascular surgery residency, National Heart Institute, Bethesda, MD, 1968-70;fellowship, cardiovascular surgey, Johns Hopkins Univ., Baltimore, MD, 1971-73; died January 31, 1998, age 58.

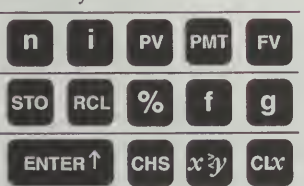
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Mississippi Institutions and Organizations Accredited as Providers of Intrastate Continuing Medical Education

The following medical institutions or organizations have been accredited as providers of CME by the MSMA's Council on Medical Education. Accreditation is awarded in accordance with the ACCME's/*MSMA's* ***"Essentials for Accreditation of Sponsors of Continuing Medical Education" and "Standards for Commercial Support of Continuing Medical Education."*** Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing or calling the Director or Coordinator of Continuing Medical Education at the individual institution or organization.

Baptist Memorial Hospital-Golden Triangle
2520 - 5th Street North
Columbus, MS 39701

Baptist Memorial Hospital-North MS
2301 South Lamar Street
Oxford, MS 38655

Biloxi Regional Medical Center
150 Reynoir Street
Biloxi, MS 39530

Charter Behavioral Health System
3531 East Lakeland Drive
Jackson, MS 39296

Council on Scientific Assembly
MS State Medical Association
735 Riverside Drive
Jackson, MS 39202

Delta Regional Medical Center
1400 East Union Street
Greenville, MS 38704

Forrest General Hospital
Mamie Street & Highway 49 South
Hattiesburg, MS 39404

Greenwood Leflore Hospital
1401 River Road
Greenwood, MS 38930

Grenada Lake Medical Center
960 Avent Drive
Grenada, MS 38901

Jeff Anderson Regional Medical Center
2124 14th Street
Meridian, MS 39301

King's Daughters Hospital
300 South Washington Street
Greenville, MS 38702

Medical Assurance Company of Mississippi
735 Riverside Drive, Suite 301
Jackson, MS 39202

Memorial Hospital at Gulfport
4500 13th Street
Gulfport, MS 39502

Methodist Medical Center
1850 Chadwick Drive
Jackson, MS 39204

MS Baptist Medical Center
1225 North State Street
Jackson, MS 39202

MS State Department of Health/
MS Association of Public Health Physicians
Post Office Box 1700
Jackson, MS 39215

Natchez Regional Medical Center
54 Sergeant S. Prentiss Drive
Natchez, MS 39121

North MS Medical Center
830 South Gloster Street
Tupelo, MS 38801

Northwest MS Regional Medical Center
1970 Hospital Drive
Clarksdale, MS 38614

Rush Foundation Hospital
1314 19th Avenue
Meridian, MS 39301

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39581

St. Dominic-Jackson Memorial Hospital
969 Lakeland Drive
Jackson, MS 39216

Wesley Medical Center
5001 Hardy St.
Hattiesburg, MS 39404

Membership Benefits

Representation, advocacy, public relations and support of professional ethics are some of the reasons MSMA exists for its members. These are the intangible but important benefits of membership which MSMA seeks to provide through member participation. There are also more tangible benefits which the association provides its members. Illustrated here are the MSMA-sponsored programs for such member needs as insurance and practice management support. These programs are listed below.

MEMBERSHIP HOTLINE
The MSMA provides a toll free WATS for any member to call to inquire about medical matters and programs of the association. Inquiries about AMA programs and policies can also be made over a membership WATS line.

MEDICAL OFFICE SUPPLIES
MSMA members can save up to 40 percent on medical office supplies through "AMA Purchase Link". Under this program discounted medical, surgical and pharmaceutical products are available from Henry Schein, Inc., the largest nationwide distributor of such products to physicians' offices.

THIRD PARTY PAYOR LIAISON
MSMA conducts liaison with Travelers Medicare, Medicaid and other third party payor programs on behalf of its members. Individual claim problems, as well as general policy matters, are important aspects of this liaison. For further information call Jackye Wiebelt at MSMA.

HEALTH INSURANCE
MSMA members who are organized as PAs and wish to provide health insurance coverage for their employees are eligible to participate in a self-insured 501(c)(9) trust sponsored and administered by a subsidiary of the association. For information contact Jackye Wiebelt at MSMA.

WORKERS' COMPENSATION INSURANCE
The MS Physicians Insurance Company (MPIC) is affiliated with MSMA and currently provides workers' compensation coverage to physicians' offices at the lowest rates available. MS law requires every employer with five or more employees to obtain such insurance. For further information contact Gusta Stanford at MPIC.

PRACTICE MANAGEMENT
Through an arrangement with the AMA Department of Practice Management, MSMA periodically conducts practice management workshops for physician's office personnel. These workshops cover a broad range of topics from CPT-IV coding to patient surveys. For further information call Jackye Wiebelt at MSMA Diversified Services, Inc.

DEBT COLLECTION SERVICE
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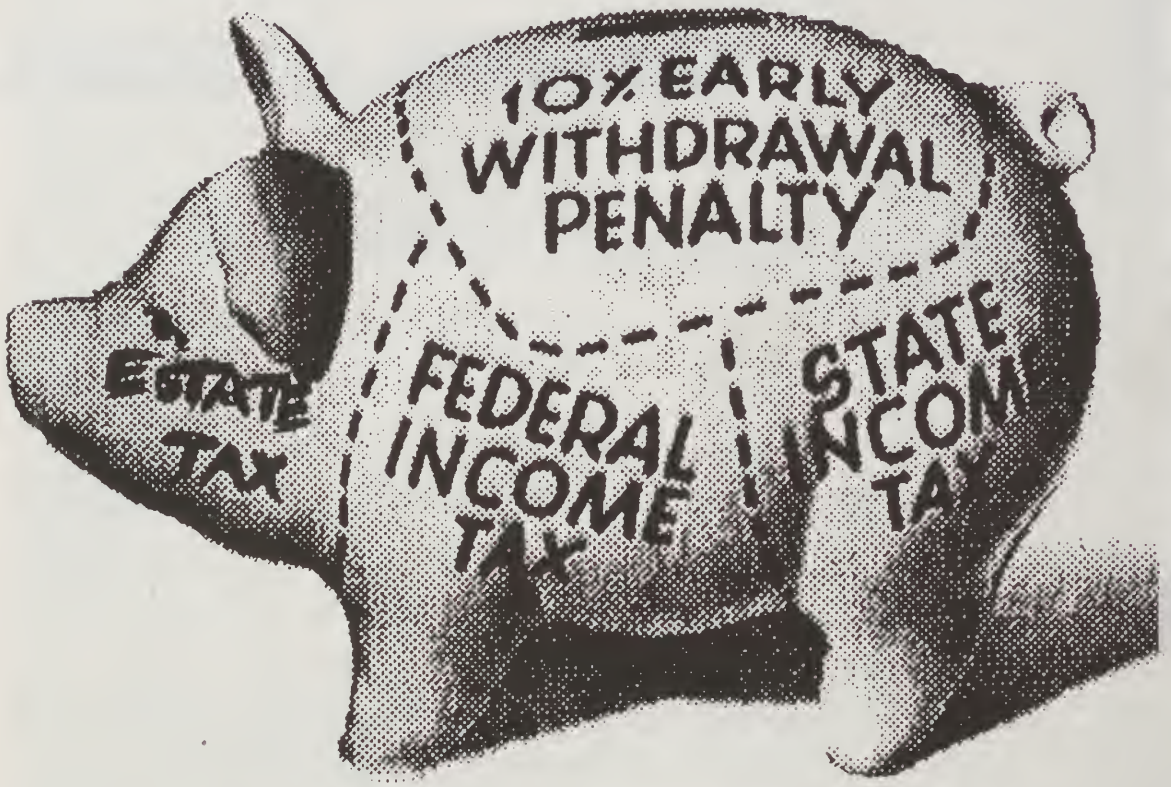
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Comparison of Insulin Regimens and Administration Modalities in Pregnancy Complicated by Diabetes

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Suneet P. Chauhan, M.D.
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John C. Morrison, M.D.

Abstract

Purpose: To compare insulin administration using premixed insulin (70% NPH/30% Regular) by an injectable pen with traditional self-mixed insulin administered by syringe.

Methods: In this study, 93 women were enrolled into four groups: 1) self-mixed/syringe, 2)premixed/syringe, 3) self-mixed/pen, and 4)premixed/pen.

Results: Women in the premixed pen group had significantly less cesarean deliveries for failure to progress in labor and a decrease (not significant) in postpartum infection and infant macrosomia. Patients felt premixed insulin administered by the pen was easier to use. No significant differences were noted in glucose control, compliance among the four groups, or cost.

Conclusion: Premixed insulin administration via the pen is safe, effective and no more costly than traditional treatment for pregnant diabetic women.

Key words: Diabetes, Pregnancy, Premixed Insulin

Introduction

Rigid glucose control among diabetic patients improves the perinatal outcome.[1] Elevated maternal glucose levels in early gestation are associated with a threefold increase in congenital anomalies.[2] Prolonged hyperglycemia during pregnancy has long been associated with abnormal growth of the fetus, intrauterine fetal demise, traumatic delivery, operative procedures, neonatal hypoglycemia, and hypocalcemia.[3] One method to reduce such adverse outcomes is to rigidly control glucose excursions by maintaining a fasting glucose less than 100 mg/dl and less than 120 mg/dl after meals.[4] The conventional method of administering insulin to pregnant women usually consists of subcutaneous injections twice daily with intermediate-acting insulin and regular insulin.[5]

The difficulty with this approach is noncompliance. Studies indicate that physicians overestimate the degree of glucose control achieved by their patients and that providers are unable to predict accurately the likelihood of individual compliance.[6] Alternatively, a continuous infusion of insulin via an external pump is recommended for the same patients who have extreme variations in glucose levels despite conventional therapy.[7] The pump, however, for the majority of patients is too costly and not required. Thus, a new method of administering insulin to diabetic patients which will improve compliance, glucose control, and obstetric outcome would be beneficial. Utilizing premixed insulin with an injectable pen is a technique which has demonstrated similar efficacy as traditional subcutaneous injections among nongravid patients.[8] There are, however, no reports regarding the use of premixed insulin with the pen in pregnancies complicated by diabetes.

The purpose of this prospective study was to assess the efficacy of this mode of administration and

compare it to the glucose control obtained with conventional split-dose/self-mixed insulin therapy in pregnant women with diabetes.

Methods and Materials

Patients eligible for this study included pregnant women with insulin-dependent diabetes who initiated prenatal care at the University of Mississippi Medical Center. The study was approved by the Investigational Review Board of the University Medical Center. Inclusion criteria were insulin-dependent diabetes, maternal age 15 to 44, < 20 weeks' gestational age at entry, and willingness to sign an informed consent form.
Exclusion criteria were additional pregnancy complications which might effect maternal/infant outcome (hypertension, placenta previa, fetal malformations, and glucose intolerance not requiring insulin), unwillingness to comply with prenatal care/aggressive glucose control, and patient refusal to participate.

Women who met inclusion criteria were identified by the obstetric clinic personnel and the study was addressed by obstetric nurses trained specifically as a diabetic educator. After screening for exclusion factors, one of the physician authors were contacted and the patient was asked to sign an informed consent form after the study was explained. Randomization was carried out by selecting an opaque, consecutively-numbered envelope in which computer-generated randomization cards were placed to assign patients into one of four groups. Women in group 1 used conventional self-mixed regular and NPH insulin twice each day. Group 2 patients used premixed 70NPH/30REG insulin® (Squibb Novo, Inc., Princeton, NJ) with conventional syringes and needles as in the first group. Women in group 3 administered self-mixed split-dose regular and NPH insulin using the NovolinPen® (Squibb Novo, Inc., Princeton, NJ) twice per day. Group 4 gravidas used premixed 70/30 insulin administered in the NovolinPen®.

All subjects underwent initial evaluation of their current level of glucose control. Intensive education regarding capillary glucose home monitoring was carried out by nurse educators. During the initial assessment, ultrasound confirmation of gestational age and a survey of fetal anatomy was performed. All patients were placed on appropriate diabetic ADA diets for pregnancy based on their weight, food preference, and activity level. At each prenatal visit (two-week intervals) women were continually educated about the importance of diet, activity and insulin administration on glucose homeostasis. Each patient was assigned to one of the diabetic nurse educators and given a work and home number so that patient contact could be carried out 24 hours per day, 7 days per week if questions about glucose control were raised.

Patients performed capillary glucose monitoring each day in the fasting state as well as a two-hour postprandial assessment after breakfast, lunch, and dinner. Insulin adjustment was carried out to achieve fasting capillary glucose levels of > 60 and < 100 mg/dl and 2-hour postprandial levels of > 80 and < 130 mg/dl. Appropriate insulin adjustments were made by the house officers and approved by the obstetric staff in attendance.

Scores were assigned to each patient by these nurses at the end of each gestation that reflected overall patient compliance as demonstrated by diet assessment, adequate glucose monitoring, insulin usage, and appropriate follow-up with physician instructions and visits. The scoring system was based on a numeric 1 to 5 scale (1 = good compliance, 2 = better-than-average compliance, 3 = average compliance, 4 = worse-than-average compliance, and 5 = poor compliance).

Serial sonography was performed on all subjects beginning at 28 weeks' gestation for evaluation of interval growth. Weekly antenatal fetal health assessment tests were initiated at 32 weeks' gestation. The timing of delivery was dependent on glucose control, obstetric history, and the results of antepartum surveillance. Intravenous crystalloid solutions were administered to all patients during labor and intravenous glucose/insulin infusions were initiated on all patients whose capillary glucose monitoring was > 105 mg/dl. The mode of delivery was based on overall clinical evaluation and response to labor. House staff managing the patient were unaware of the treatment regimen to which the patient was assigned during the antepartum period.
Appropriate glucose monitoring of the infant was performed by the pediatric department. Pediatricians supervised all neonatal resuscitation and nurses assigned the Apgar scores.

The following variables were evaluated during the study: gestational age at delivery, number of prenatal visits, cesarean deliveries for arrest disorder in active phase, pregnancy-induced hypertension, preterm labor, abruption, chorioamnionitis and endometritis, maternal and neonatal hospitalization days, infant weight, macrosomia, and 1 and 5 minute Apgar scores as well as infant complications such as hyperbilirubinemia, hypocalcemia, hypoglycemia, and incidence of admission to the neonatal intensive care unit. All outpatient capillary glucose assessments performed during the pregnancy were also evaluated.

Statistical analysis was performed by chi-square or

analysis of variance followed by Student Newman-Keul's test. $P < 0.05$ was considered significant.

Results

Of the 100 patients enrolled in the study, 93 were available for outcome analysis. Two women suffered spontaneous abortions, two underwent elective termination, and 3 were lost to follow-up. These seven women were equally distributed among the four groups (1/1/3/2). Table 1 lists the demographics of the 93 patients and their randomization into the four study groups as described. There was no significant difference in age, parity, race, number of prenatal visits, or White's classification among the groups.

The number of antepartum glucose measurements performed during this study was 10,974 with an average number of 131 measurements per patient. The group values are listed in Table 2. Analysis of variance indicates that there was no statistical significance in fasting or postprandial glucose levels among the four groups.

Table 3 reveals the maternal and neonatal outcome parameters among the four groups. There was a significant difference ($P = 0.03$) between the groups in regard to cesarean delivery performed for cephalopelvic disproportion (CPD). None of the cesarean sections performed in group 4 was for CPD while 28% of the abdominal operations in group 1 was for this indication. Abdominal delivery for other reasons such as fetal distress (3) or malpresentation (2) was equally distributed between the four groups. The incidence of maternal peripartal infection approached significance ($P = 0.06$) with a 44% incidence in group 1 and a 13% incidence in group 4. Except for two wound infections, all of the infections were related to endomyometritis.

Maternal hospital days were similar and were not significantly different between groups. The subjective compliance score revealed no statistically significant difference, although the best score was achieved in group 4. Consistently, patients in that group were more compliant in the opinion of the diabetic nurse educators. The birth weight among group 4 neonates was averaged almost 150 gm lighter than the other three groups and the difference was almost statistically significant ($P = 0.07$). There were 6 gestations complicated by fetal macrosomia (≥ 4000 gm) and none of them were in group 4 (group 1 = 3; group 2 = 2; group 3 = 1). Finally there was no significant difference between groups in the other variables (1 and 5 minute Apgar scores, incidence of pregnancy-induced hypertension, preterm labor, infant hyperbilirubinemia, and hypoglycemia).

Discussion

Traditionally, euglycemia in diabetic patients has been achieved with self-mixed insulin administered via multiple injection techniques. New modalities in glucose control include premixed insulins, insulin infusion pumps and insulin pens. Although the pumps have shown improved glycemic control in the nongravid diabetic patient, they have demonstrated no difference in glycemic control or outcome in the gravid population and they are costly.[7] Published studies have noted the ease and convenience of using the premixed insulins with insulin pens and have demonstrated similar glycemic control compared to traditional methods among nongravid patients.[7,8,9] There are, however, no reports on the efficacy of using the premixed insulins or insulin pens in pregnancies complicated by diabetes.

This prospective randomized study demonstrates the effectiveness and safety of using both premixed insulin administered by injectable pens in the management of pregnancies complicated by diabetes. Parturients managed with premixed insulin delivered via insulin pens had similar capillary glucose measurements in the fasting and postprandial state as women who received traditional methods of insulin administration. No maternal or neonatal adverse effects were noted and, in fact, there was a significant decrease in the rate of cesarean deliveries for cephalopelvic disproportion among the patients who were managed with the premixed 70/30 insulin administered with the insulin pen as opposed to traditional self-mixed insulin using syringes. While not significant, the lack of macrosomic fetuses in group 4 (premixed/pen) may account for the diminished rate of abdominal deliveries. This may be in part due to better glucose control but his hypothesis could not be confirmed by our data due to small numbers of patients. Although there was consistently lower glucoses in group 4 the differences were not significant (Table 2). In part, due to the reduced rate of abdominal delivery, there was a decrease in the rate of peripartal infection among the parturients who used the premixed insulin with the insulin pen.

The cost of the NovolinPen® ($39) with premixed insulin is similar to using the disposable syringes ($36). There is no difference in the cost of insulin (cartridges versus conventional vials) in the cost per injection (10 cents with the pen versus 7 cents using the syringe). Cost aside, one of the benefits of premixed insulin with the NovolinPen® appears to be increased compliance and ease of administration. The diabetic nurse educators subjectively noted that almost all patients were very receptive to the use of premixed insulin in the NovolinPen® as they found this system more convenient and easier to

Table 1. Maternal Demographics

	Group 1 SM/SYR (N = 24)	Group 2 PM/SYR (N = 24)	Group 3 SM/PEN (N = 22)	Group 4 PM/PEN (N = 23)	P
Age	27.9 ± 6.1	27.9 ± 5.7	28.2 ± 5.6	28.7 ± 5.4	NS
Parity	1.7	1.6	1.5	1.5	NS
Race					
C/AA/NA	1/21/2	2/21/1	2/19/1	34/19/1	NS
Prenatal visits	12.8 ± 7.2	13.2 ± 5.0	12.3 ± 5.5	13.9 ± 6.8	NS
White classification					
A2	10	10	9	14	NS
B,C	12	13	11	8	
D,F	2	1	2	1	

SM, self-mixed; PM, pre-mixed 70/30; SYR, syringe; PEN, NovolinPen®; C, Caucasian; AA, African-American; NA, Native American

Table 2. Antepartum Capillary Glucose Measurements (mean ± SD, mg/dL)

	Group 1 SM/SYR (N = 2660)	Group 2 PM/SYR (N = 2133)	Group 3 SM/PEN (N = 1860)	Group 4 PM/PEN (N = 3565)	P
Fasting	114.1 ± 31	96.5 ± 22.3	103.2 ± 26.2	108.5 ± 25.8	NS
Breakfast*	141.5 ± 41.9	127.4 ± 30.7	130.6 ± 33.7	130.6 ± 32.1	NS
Lunch*	148.9 ± 37.9	130.2 ± 29.2	134.6 ± 33.2	132.7 ± 27.9	NS
Dinner*	143.2 ± 43.6	134.4 ± 31	134.9 ± 34.1	132.9 ± 29.9	NS

SM, self-mixed; SYR, syringe; PM, pre-mixed 70/30; PEN, NovolinPen®; *2-hr postprandial

Table 3. Maternal and Neonatal Outcome Among the Four Groups

	Group 1 SM/SYR (N = 25)	Group 2 PM/SYR (N = 24)	Group 3 SM/PEN (N = 22)	Group 4 PM/PEN (N = 23)	P
Gestational age (wks)	37.0 ± 2.9	37.9 ± 1.9	37.6 ± 2.0	36.3 ± 4.1	NS
Abdominal delivery for CPD	7 (28%)	7 (29%)	5 (23%)	0	0.03
Infection rate	11 (44%)	6 (25%)	6 (27%)	3 (13%)	NS
Maternal hospital (days)	4.5 ± 2.8	4.4 ± 2.3	4.3 ± 2.1	3.4 ± 1.4	NS
Compliance score (1-5)	3.0 ± 1.7	3.0 ± 1.4	3.3 ± 1.4	2.3 ± 1.5	NS
Birth weight (g)	3254 ± 702	3146 ± 579	3100 ± 517	2978 ± 869	NS

SM, self-mixed; SYR, syringe; PM, pre-mixed 70/30; PEN NovolinPen®; CPD, cephalopelvic disproportion; NICU, newborn intensive care unit

use. This supports the National Lifestyle and Experience Survey conducted on 7792 nongravid patients using this technology.[10] After using the NovolinPen® for one year, over 80% of the diabetics surveyed preferred to continue using this delivery system.[10]

In summary, this prospective randomized study indicates premixed insulin delivered with an insulin pen is safe and efficacious in managing pregnancies complicated by diabetes. This new system is simple to teach and administer. A benefit of using premixed insulin and the NovolinPen® compared to the self-mixed insulins in traditional syringes in our study was a significant decrease in abdominal delivery due to arrest disorder in the active phase of labor. A larger study will be required to demonstrate potential significant improvement in glycemic control and substantial reduction in birth weight using this system of insulin administration.

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Pitfalls in Industrial Drug Screening

Jim Adams, M.D.

Abstract

Physicians need to establish a protocol for drug testing. Drug testing is, by its nature, often adversarial. Despite the confusing lack of standardized methods for handling positive and negative industrial drug tests, both pre-employment and random, physicians must be methodical in adhering to basic principles of privacy and careful in the interpretation of positive results. Errors in handling drug testing have and will continue to lead to avoidable lawsuits.

Key Words: Drug Testing, Industrial

Physicians are increasingly called upon to perform either pre-employment drug screens, random drug screens, or post-accident drug screens for industry. Some have already experienced those few chilling, insecure moments when pressed to remember the pharmacology of illicit drugs or perhaps respond with an unconvincing answer to the inevitable denials that often follows illicit drug detection. This article, in no way exhaustive on the subject, will cover some common pitfalls in office drug testing programs.

There are two major protocols for drug testing, NIDA and non-NIDA. NIDA standards are the rigid, well-defined guidelines for the Department of Transportation (DOT) which, for example, covers all commercial drivers and maritime workers. (Note: NIDA has recently been changed to SAMHSA, Substance Abuse and Mental Health Service Administration, but most forms still carry the NIDA abbreviation.) Perhaps there may come a time when NIDA regulations are standard for *all* drug screens, but for now, industries may still specify alternate drug testing protocols or requirements if they stay within certain legal boundaries. In performing NIDA drug screening, the laws are very clear with particular "do" and "do-nots" which everyone in the drug testing business must know. For instance, the drug tests for DOT physicals must be sent to a NIDA-certified lab for testing. Urine quick-tests and the local hospital labs are not adequate, unless your hospital lab performs the test by gas chromatography/mass spectrometry *and* is NIDA-certified.

Industrial drug tests may be of several types: 1) Pre-employment, 2) random, or 3) reasonable suspicion. The titles are self-explanatory, but it is imperative that the requesting industry accept responsibility for the policies concerning all three. Though the testing physician is not responsible for a sloppily or hastily conceived drug policy, as the agent of the requesting industry, a physician should never knowingly participate in the collection and testing of individuals when the policy of the industry is deemed illegal. Check with a lawyer. Fortunately, most companies consult with attorneys before putting their policies in effect. However, there are those who don't. Random drug screens must be truly random and never used to single out an employee for punishment. If a *confirmation* returns positive, the employer then may know the results including the name of

the drug, but in cases where prescription drugs are documented, the employer has no legal right to the information, and the responsible doctor should report the test simply as "negative" without elaboration. Positive initial screening tests should *not* be reported at all. *Wait for the confirmation.* Many times, I have seen positive screening tests for marijuana, even with significantly high levels, return *negative* on confirmation!

Be aware that there are different cutoff limits for positive screening and confirmation tests. Some industries performing non-NIDA screens demand zero tolerance on drug tests, but, using marijuana for example, NIDA sets cutoff levels designed not to punish those who rightly claim to have been exposed to passive smoke. I insist on using NIDA confirmation levels. Some drug testing companies use different cutoff levels, but will agree to change them at the doctor's request. If the employer chooses to enforce zero tolerance levels, have them give their policy to you in writing and explain to them the facts — only gas chromatography/mass spectroscopy yields infallible results, and (using marijuana again) any confirmation test value 15 ng/ml or less may be the result of passive inhalation of smoke. Many potential employees come to their physicals knowing that marijuana stays positive in the urine for weeks or even a month, and consequently, borderline levels are common.

Drug testing is a confrontational act often perceived as an infringement on personal liberty that frequently causes ill will. Anyone doing drug testing long enough will be called upon to defend their procedure. Anyone under the employment of the physician doing drug testing should have a written protocol and follow it explicitly with no exceptions. This protocol should be explained carefully to any substitute lab technicians or nurses involved in the process. Some key elements of the collection process are as follows:

1) NIDA is different. You cannot ask a person for a NIDA drug test to produce a list of current medications. If a drug shows up in the urine, the employee can then produce a legitimate, current prescription *in his or her name*, to negate a positive test.

2) A prescription has to be the *employee's own* prescription. On a non-NIDA test, if it is your desire to communicate with the employer about an invalid prescription in someone else's name, be careful! For example, say the patient claims to have taken the spouse's pain killer. Divulging this fact crosses the line into the rights of privacy of the spouse and can have legal repercussions.

3) Make sure the responsible party or their substitutes have a complete understanding of the Chain of Custody (COC) form. Dot your "i"s and cross your "t"s. Testing companies will refuse to run the test even for minor irregularities or missing information on the COC form. (Hint: It helps to have a compulsive personality type handling drug testing protocol. Drug testing is no area for sloppiness.)

4) The employee should not drink more than five glasses (8 oz. cups) of water if they need to hydrate to get a specimen. Over dilution of the urine specimen causes dilutional errors. NIDA specifies no more than five, 8 oz. cups.

5) The collection room should have neither running water nor a soap dispenser. The commode must have a bluing agent which should be changed regularly. One of the old tricks was to use clear dish detergent in the specimen to prevent the detection of marijuana. Now labs, and even the quick tests presently available, check for "interfering substances." A NIDA test found to have "interfering substances" is reported *positive*. Running water in the room will tempt the unsuspecting employee to use tap water. This usually fails, as all commercial urine testing cups come with temperature strips to detect the temperature of the specimen. The proper and acceptable range is from 90° to 100° Fahrenheit (32° to 38° Celsius). Criteria for the temperature of the specimen *must always be met*. Potential employees who know the system have become fairly ingenious, including urine collection bags strapped to the thigh. Specimens should be checked immediately and not later than four minutes after collection. Obviously, the lab person doing the drug collection must be free to dedicate all attention to the procedure without interruptions.

6) The employee is not allowed to go into the bathroom for collection with a hat or coat or bag.

7) The employee does not (and should not) be observed for a routine collection. If the company requests observation, this is acceptable. The request should be documented. The employee may be observed, by a member of the same sex, if there is sufficient reason to suspect that the employee may alter the specimen. This includes the employee who presents the collector with a cold or hot specimen at least 1.8° outside the acceptable range, the employee who presents a specimen too dilute (defined as a specific gravity of less than 1.003 or with a creatinine less than .2 g/L), or if there is an obvious attempt to alter the urine, as with blue dye in the specimen, or if the patient has previously been found to have a positive drug test and is returning to work under DOT regulations.

8) The employee always hand-carries their own specimen directly to the collector, and the collector asks the employee to witness the sealing of the specimen with

appropriately initialed tape bearing the initials of the collector, the employee, plus the employee's social security number and the date. This becomes a critical point for those cases who allege errors were made in collection. The collector ritualistically tells the employee to watch as they tape the urine specimen for shipment. The urine with the signed tape will sit (if positive) for a year in a refrigerated vault. This is the same for NIDA or non-NIDA.

A few comments are in order about the testing methods used. Gas chromatography with mass spectrometry is the one and only gold standard for urine testing. Breath alcohol testing using equipment approved by the DOT is the alcohol testing gold standard. Technicians who perform DOT alcohol breath testing should be certified through a standard course in training (Breath Alcohol Technician, BAT) to use the breath alcohol analyzer under the strict requirement of the DOT. Realize that alcohol testing will surely be performed in litiginous situations. This is an area where strict protocol is imperative. For instance, the technician must be in the room alone with the employee, the data (name, date, technician, etc.) required by the DOT must show on the test strip, and the proper interval must be obeyed between a positive test (over 0.02) and the confirmatory test. All these rules may seem trite on the surface but are established for scientific and legal reasons that will certainly return to haunt anyone who flaunts the protocol.

The older blood alcohol levels are still used by some people but are less used in comparison to the quick accuracy of breath analysis. Urine alcohol testing is done by some companies. Alcohol diffuses into blood, urine, and breath quickly and proportional to time and elimination. But urine is stored in the bladder where the effects of fluid intake and state of hydration cloud the validity of the results. I discourage urine alcohol determinations in general, though non-NIDA screens sometimes include them.

Antidotes

Some antidotes are appropriate in a discussion of drug testing. My favorite one involves the man who presented me with a specimen positive for opiates who angrily informed me that he had obtained codeine cough syrup over the counter. Despite my contempt for this man's story, a tedious series of phone calls to a Wal Mart store in Ohio yielded the surprise information that in Ohio, one could obtain an opiate containing cough syrup over the counter! Had I prohibited this man from working on the basis of my confirmation test, I would have violated this man's rights and certainly exposed myself to litigation. Though the employee's story may sometimes *seem* improbable, the physician in charge of drug testing should go through the motions of investigation.

In another case, PCP (phencyclidine, Angel Dust), shows up in an employee's urine. The patient emphatically denies drug use. Feeling a degree of uncertainty, I called a Medical Review Officer for the company which confirms our drug positives and found that over-the-counter Robitussin DM® seems to cause a "cross reaction," a false positive for PCP. I elected to call the test negative when I asked the employee about any over-the-counter medicines to which the employee volunteered the use of Robitussin DM®.

There must be a physician responsible for interpreting the results of a positive drug screen and the dispensation of those results. In current jargon, this person is the MRO, the Medical Review Officer. Despite a physician's extensive exposure to drugs and pharmacology, most of us are inadequately prepared to tackle the legal nuances of determining interfering substances. The rule of thumb is to call when in doubt. Most physicians know that even a small amount of poppy seeds will cause a positive urine for opiates (codeine, morphine), but how many are aware that decongestants may interfere with the *screening* (not the gas chromatography/mass spectrometry) test for amphetamines? When in doubt, the head of the laboratory performing the drug test can probably clarify any doubts of interfering substances or answer general questions that may have been raised by a doubtful employee. The MRO's comments should be documented on the employee's record.

The MRO has several other obligations to the employee. Ultimately, it is the job of the MRO to call the test either positive or negative. But remember, the MRO is under legal obligation *not* to discuss an employee's legitimate prescriptions with anyone. The MRO also acts as a source of referral for drug problems, especially and most commonly cocaine abuse. A convenient referral source where people can seek help with drug problems transforms the drug testing program into something more than a mere punitive arm of the war on drugs.

Physicians acting as MROs are obligated to make an attempt to call the employee first and explain the test before calling the results to the employer. This often becomes complicated. First, one often cannot reach the employee at home. At this point, care is necessary not to breach the confidentiality of the employee. I never leave a phone message unless the answering service states the name of the employee, and even then, I never

leave a message to call "Dr. Adams," but always "Jim Adams." You never know who will be listening to the message. I state clearly that it is important for someone to return my call the same day. If, by closing time, no one returns the call, I call the employer. On a piece of paper to remain with the employee's permanent drug testing record, I record the time of every call, the number of rings (with hash marks), and the results of the call. And, by the way, industrial drug testing records should be kept separate from any other personal records. If I reach the employee, I make a note whether or not the employee denied drug use and that I offered to discuss the test and offer counsel with someone in the drug treatment field. Cocaine users often appreciate and frequently accept the offer.

After reaching or failing to reach the employee, the next step is to call the employer to report the results. If I could not reach the employee, I offer to talk to them when or if the employer talks to them. We have a form in my clinic which reports the pertinent identifying facts and results of the drug test which we send to the employer in an envelope clearly marked "Confidential."

Be careful to establish exactly with whom you should report drug screens when you call the company. Ideally, there should be only one person who takes the results of drug screens. This person should understand the essentials of privacy and employee rights. Under no circumstances should you leave the results of a positive drug screen on an answering device where an unauthorized person may overhear the results. If an employee asks for positive results over a FAX machine, make sure the FAX machine sits physically in a place where passers-by will not see confidential information. Again, positive drug screens are frequently associated with frustration, hostility, or with occasional threats of litigation. Always show compassion for the person whose job is being denied or taken away for a positive drug test, offer help, and do nothing to insult their right to privacy. Only the designated person at the place of employment, the employee, and you have the right to know of a positive test.

What do you do when a person disputes the validity of the results? There are legal obligations for the testing facility to store the urine for a year, as mentioned above, during which the employee has the right — at their own expense — to have the specimen retested. Usually, the employee wishes to collect a new specimen, but this is not allowable to negate a previous, positive test. If you collected the test properly, it helps to remind them that the specimen on hold in the lab is the same one with the employee's name, social security number, and date, the same one he personally witnessed being taped to the specimen container on the day of collection. A meticulous and systematic collector goes a long way to defusing the employee's complaint or suspicions (or wish) that somehow an error was made. The employee may also request that the specimen be sent to another testing facility. As often as I have offered to help a person retest their urine against a backdrop of threats and protests of irregularities, in the last three years I have *never* had a employee return to demand the repeat test.

Eventually, someone will storm angrily into the office over a positive drug screen. Personally, I try to defuse this situation quickly by letting the angry employee know up front that I regret their loss of the job and even, depending on the case, that I regret the necessity for the "War on Drugs" and the invasion of privacy inherent in random drug screen programs. I emphasize that I only act as an agent for the requesting party, and that I will be glad to review their test, the methods used, and address any concerns over possible drug interferences with them.

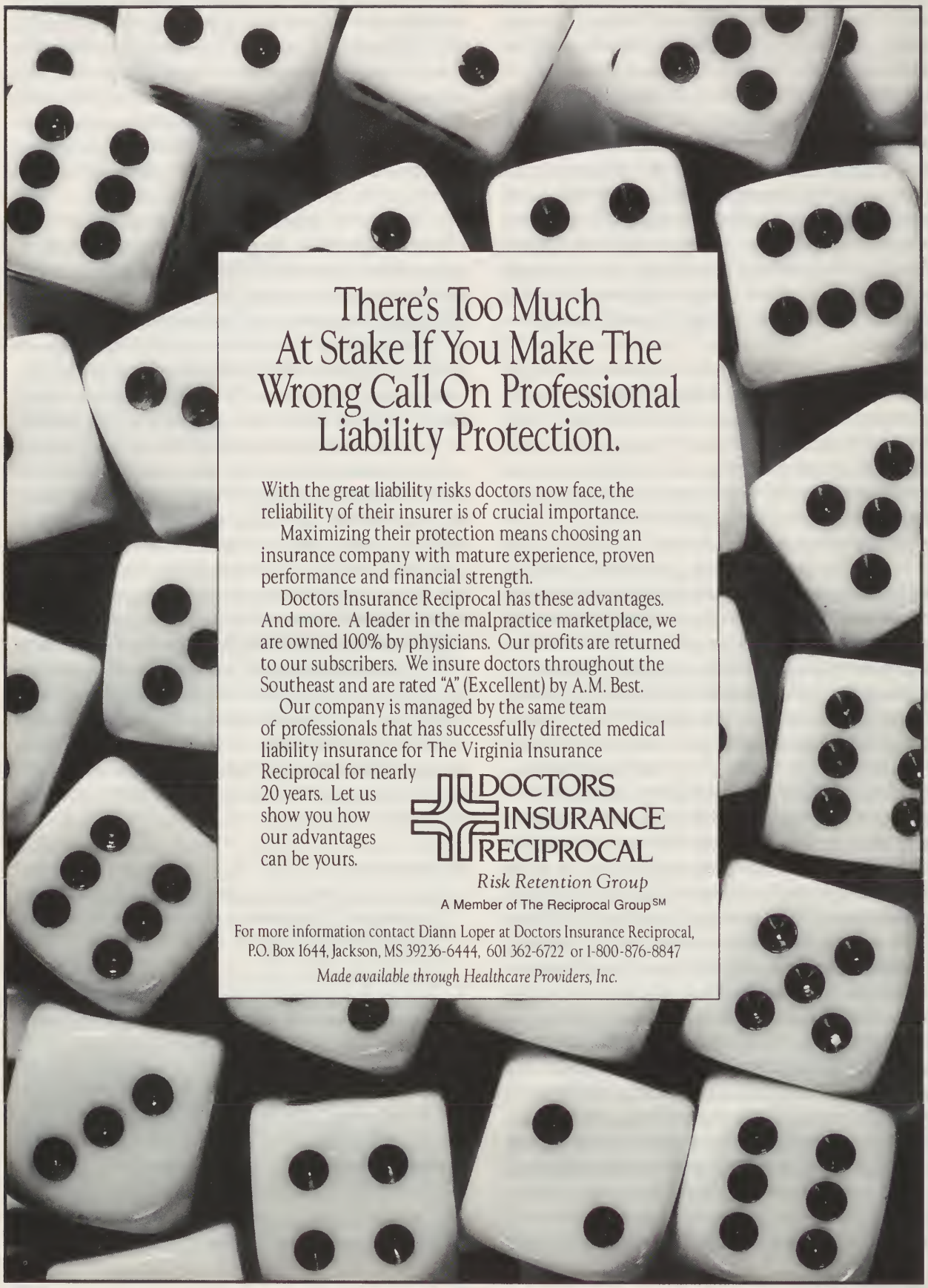
Personally, I agree with those who complain that random drug screens, not pre-employment screens, breech the constitutional protection of individual privacy. I empathize. But, sadly, serious drug use is, as I write, spreading through our society, reeking almost unimaginable havoc. Whether one agrees or disagrees with the philosophy of the "war on drugs," one cannot deny the appropriateness of the "war" analogy. To doctors afraid of the legal or even the moral implications of drug testing, I point to the casualties of this silent, insidious war. I can empathize, with the problems that lead to drug use, but physicians are healers and cannot take a passive role in the war on drugs when the evidence points so clearly to the ever increasing toll of an epidemic which knows no boundaries.

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In documenting unlisted services, include a description of the procedure, medical necessity, a statement of time and effort required for the procedure, and comparisons with other existing codes. Be sure to attach a fee to your services to assist payers in developing reimbursement allocations.

For example, a physician developed a new surgical procedure through a laparoscope. CPT describes an incisional procedure only. According to AMA guidelines, it would be inappropriate to submit the service using the incisional procedure as it does not describe the actual service or consider the different risk factors involved. To correctly report the service, use the unlisted surgical laparoscopy code, 56398, and submit supporting documentation.*

Q. Do insurance companies recognize specialization within a speciality? Do they use different criteria to determine reimbursement for an orthopedist who specializes in backs versus a general orthopedist treating a back problem?

A. In response to the first part of your first question, insurance companies generally do not recognize specialization within a specialty. Insurance companies use one of two methods to calculate reimbursement for a service or procedure. Carriers use either a relative value study or a mean average based on usual, reasonable, customary criteria. Payment is not based on the fact that a physician has elected to see patients with specific problems such as upper or lower extremities, backs, or knees. Carrier reimbursement will be the same no matter the specialization. Accordingly, carriers who use relative value studies will reimburse any physician who is qualified to provide a service the same amount of money they would have reimbursed a specialist for the same service.

CODING TIP

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It is the aim of the Institute to initiate practical dialogue with physicians, to facilitate the exchange of diverse ideas and positions, and to contribute academic insights into complex ethical issues. These goals are achieved through a variety of Institute-sponsored activities, including:

- Conferences and seminars which provide a platform for the timely discussion of current ethical concerns.
- Educational intervention services which furnish physicians with practical, hands-on training they can use in their day-to-day interactions with patients and colleagues.
- Speeches, publications, and periodical articles which delve deeply into today's most pressing issues.
- Research papers and amicus briefs for the courts which help to shape policies and guidelines.

An Institution for Scholarly Research

Founded as an academically independent organization, the Institute strives to enhance the caliber of medical ethics by participating in the study of topical issues and encouraging the open discussion of differing opinions and viewpoints.

The Institute enjoys a close working relationship with the AMA and with the AMA Council on Ethical and Judicial Affairs (CEJA), which sets association policies regarding ethics. For example, Institute staff will often work with CEJA personnel on common projects, and Institute research is often used as the foundation in developing new policies issued by CEJA.

If you would like to learn more about the objectives or projects of the AMA Institute for Ethics please call (312) 464-4075. Or, visit the AMA on-line at http://www.ama-assn.org.

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Physicians' Recognition Award



Twenty-nine MSMA members were named recipients of the AMA Physicians Recognition Award. This award is presented by the American Medical Association to Physicians who have voluntarily completed a specified number of continuing medical education hours. These individuals are presented below by Medical Society.

Central Mississippi Medical Society
Phillip Kay Blevins, MD
Robert L. Hotchkiss, MD
Billy Wayne Long, MD
William Douglas Owen, MD
Nancy O'Neal Tatum, MD
Steven Eugene Zachow, MD

Coast Counties Medical Society
William L. Bass, MD
David Lee Clippinger, MD
Ben J. Kitchings, MD

Delta Medical Society
Eugene Edward Tibbs, MD

East Mississippi Medical Society
William Martin Wood, MD

Homochitto Valley Medical Society
Shanti Pandey, MD

North Mississippi Medical Society
Thomas Senter Glasgow, MD

Northeast Mississippi Medical Society
Elbert Alan Duncan, MD
William Gilbert Jackson, MD
Kelly S. Segars, MD

Pearl River Medical Society
Richard Lee Long, MD

Prarie Medical Society
Robert Keith Collins, MD
Diego J. Velasco, MD

South Central Mississippi Medical Society
Henry Leander Lewis, MD

South Mississippi Medical Society
Charles P. Bass, MD
Virginia M. Crawford, MD
Roderick Tate Cutrer, MD
John Francis Hassell, MD
Cleveland Eric Johnson, MD
Peeler Grayson Lacey, MD

Singing River Medical Society
Jeff Allen Hodges, MD
William Rowe Ehlert, MD
Paul Harold Moore, MD

Applications for the AMA Physicians Recognition award can be obtained at any time by writing or calling the **AMA Office of Physician Credentials and Qualifications: (312) 464-4672.**



Michael H. Carter, Jr., M.D.

The President's Page

"Find A Need and Fill It!"

A strange thing happened in 1977. Virtually all of the commercial insurance carriers abandoned Mississippi's medical liability insurance market. They said it was no longer a profitable business to underwrite. Some 750 MSMA members proved them wrong.

It was a little more than 20 years ago when MSMA members joined together to create one of the first (and one of the most successful!) physician-managed medical liability insurance companies in the country. Today, Medical Assurance Company of Mississippi (MACM) covers more than 60 percent of the Mississippi physician market.

The founding fathers of MACM were doing something right in 1977. To coin an old marketing maxim, they were able to "find a need and fill it." The result was a profitable business venture that offered MSMA member physicians the professional liability coverage they could otherwise have been missing.

I like to think that in 20 years we will look back to 1998 and say, once again, that MSMA was "doing something right." Mississippi physicians are rallying to capitalize a physician-managed health insurance company. Physicians Care Insurance Company (PCIC) is designed to protect physician autonomy and the precious physician/patient relationship as a growing managed care environment encroaches. I believe that PCIC can fill an empty niche in Mississippi's health care market by forming an insurance company based on these concepts:

- Patients want freedom of choice of physician.
- Physicians are uniquely qualified to determine medical necessity.
- Premium dollars should be spent on patient care.
- Fee-for-service is superior to capitation.
- Utilization review should emphasize quality care and appropriate case management.

With this premise in our hearts and the financial resources to capitalize a company in our hands, PCIC will be poised to vie for Mississippi's health care coverage business. We'll be able to fill a niche that has been overlooked in the quest for profit. In other words, MSMA has once again been able to "find a need and fill it."

Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXIX, NUMBER 6
JUNE 1998

College Selection Time, and A Lesson in Economics

My daughter, Madeline, and I have I have just finished the dizzy swirl of the college selection process, and to remove any suspense from this treatise I can tell you that she will be enrolling in Mount Holyoke College in Massachusetts this fall. I can tell you some other things, too, as the result of a process that began eighteen months ago when we first set foot on the campus of the University of Chicago to begin her search.

First of all, communism lives. One can forget about financial aid for scholars. It's virtually nonexistent. For better or for worse, financial aid is dispensed by colleges on the basis of financial need. What that produced in me was the following thought—if I was to pay a private college sticker price of $30,000 per year I wanted some prestige associated with the name. Otherwise, a state university was just fine, thank you—I graduated from one and my daughter could, too.

This idea has some obvious implications for doctors in private markets, but let me tell you of another financial lesson learned last week. Faced with a last minute decision between Boston University and Mount Holyoke College, Madeline and I decided on a trip to New England for some decision making open houses. Quick plans like this don't make for the cheapest air fares; however, I was lucky and found a $211 round trip fare to Boston from Baton Rouge. For Madeline, in a boarding school in Birmingham, the best fare on the same airline turned out to be $1300. What? And I had farther to go? It turns out that Birmingham had no five day advance fare, but the market in Baton Rouge allowed such.

What to do? When I told a physician friend about it his incredulous response was that if doctors tried this, we would either be arrested or tossed out of the Medicare program for three consecutive life terms. He was right, of course, but the lesson here is that I took Delta's deal. The other airlines didn't have good flight times for Madeline and me to fly together, and an average of $750 a person wasn't too bad for last minute bookings. When Delta agreed to bump Madeline up to first class I booked the flights. Yes, Madeline went first class while I stayed in the back with the chickens, but it suited me among the various alternatives. We had a wonderful trip.

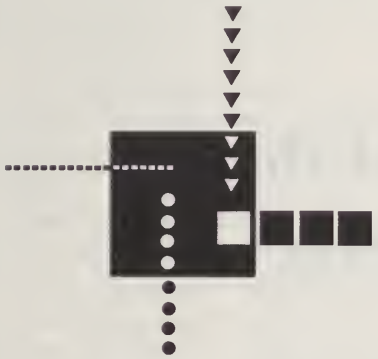
Patients in the Medicare system don't have my options. There is one set price for an office visit, and gradually fewer choices. While I still accept new Medicare patients, not uncommonly they blurt out their frustration over the difficulty of finding a doctor who would take them. What is regarded as freedom in the deregulated airline industry and in education is regarded as criminal behavior when it comes to health care.

And I will say this—HCFA can pay what they want for an office visit. That's fine. But they have no right to say what we can charge for an office visit—not in a free society.

Leslie E. England
Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

Your Success is Our Goal



American Medical Association Organized Medical Staff Section (AMA-OMSS)* Assembly Meeting

June 11-15, 1998
Sheraton Chicago Hotel and Towers
Chicago, Illinois

To succeed in today's health care environment, your medical staff needs the latest information and appropriate skills for meeting the day-to-day challenges of medical practice. By attending this meeting, you can learn about:

- **Managing physician organizations**
- **Negotiating and resolving conflicts**
- **Helping and handling the disruptive physician**
- **Emerging information technology**
- **Capitation**
- **Stark II recommendations**
- **Antitrust**
- **Organized medical staff challenges in the future**
- **Effectively communicating in business practice**
- **PSOs and Medicare risk contracting**
- **Unionizing**
- **E/M Documentation Guidelines**

In addition to these educational offerings, as an AMA-OMSS representative of your medical staff, you can participate in advocacy, policy-making and networking activities. **Our goal is to work with you to identify and address medicine's most pressing issues. We also want to help you increase your knowledge and skill so that together we can best serve the needs of patients, physicians, and the profession.**

To achieve this goal you can:

- Submit resolutions and participate in mode-of-practice and general interest forums to bring your concerns to the forefront.
- Testify at reference committee hearings and vote on actions in a democratic assembly to further AMA's advocacy agenda.
- Attend practical education programs to improve your medical practice, earn **8.5** hours of CME credit** and pay no fee to register!

Your success depends on your involvement! Plan today to attend the 1998 Annual AMA-OMSS Assembly Meeting on June 11-15, at the Sheraton Chicago Hotel and Towers. To receive more information and registration materials, please call **800 621-8335 and ask for the Department of Organized Medical Staff Services.**

* The American Medical Association Organized Medical Staff Section (AMA-OMSS) leads and assists grassroots physicians, individually and in groups, to organize and reclaim their role as medical leaders and advocates for excellence in patient care, professionalism, and the integrity of the patient-physician relationship. We provide practical educational forums, focused policy development, and grassroots support through the Federation.

** The AMA designates this education activity for a maximum of 8.5 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

American Medical Association
Physicians dedicated to the health of America

Annual Report of the Executive Director

Editor's Note: Mississippi State Medical Association Executive Director Charles L. Mathews presented this 26th and final report to the 1998 House of Delegates upon his retirement at the 130th Annual Session held May 14-17 in Biloxi.

The Executive Director staffs and administers programs under the direction of the Board of Trustees, Officers and Councils and in accordance with Chapter IX, Section 6 of the MSMA By-Laws. This report summarizes your staff's activities during the 1997-98 association year and notes other administrative matters.

1997-98 Staff Activities:

Your MSMA staff conducts the administrative activities of MSMA and its affiliated organizations. Annual reports presented at this meeting of the House of Delegates relate the current status of these activities. The following organizations are currently MSMA affiliated organizations - the MSMA Alliance, MSMA Services, Inc., MSMA Diversified Services, Mississippi Physicians Insurance Company, Inc., the MSMA Foundation, the Mississippi Physicians Care Network and the Physicians Care Insurance Company. The Physicians Care Insurance Company was incorporated during 1997-98 following directives of the House of Delegates and is presently being organized.

Managed care and health legislation issues continued to consume a large part of your staff resources during the 1997-98 association year. Staff work was also devoted to on-going association programs such as continuing medical education accreditation, membership recruitment and member publications.

MSMA Staff:

I wish to particularly acknowledge and thank those individuals who have served with me as the MSMA Staff. It has been a personal privilege for me to work with them in a team effort on behalf of the MSMA membership. The administrative accomplishments and success the association has achieved have been due to their efforts.

A Personal and Final Note:

This report marks my 26th and final report as your Executive Director. That 26 years was preceded by a nine year period as the association's first assistant executive director. I am unable to express in words the personal satisfaction and honor I have felt in working for the medical profession. You have always chosen to be on the leading edge of significant events affecting your profession. I arrived to find you pushing efforts to ensure that the legislature adequately funded the state's first four year medical school you played such a large part in establishing. Subsequently and through this annual meeting your concerns and efforts have resulted in the association implementing a wide range of projects impacting the practice of medicine and your profession. They have included in chronological order of implementation such projects as:

- Serving as fiscal intermediary in Mississippi for

the Dependents Medical Care Program for the Uniformed Services (now CHAMPUS).

• Serving as a contractor for the Experimental Medical Care Review Organization (EMCRO) project funded by Congress to demonstrate a physician directed peer review program.

• Forming the Mississippi Foundation for Medical Care (MFMC) and subsequently implementing the Professional Standards Review Organization (PRSO) in Mississippi.

• Forming the Mississippi Medical Fraternal and Educational Society (now MACM) to provide professional liability insurance to members of the association.

• Establishing the MSMA Benefit Plan & Trust to provide and administer a health benefits program for physicians, their employees and families under ERISA.

• Forming the Mississippi Physicians Insurance Company, Inc. to provide a HMO to Mississippi employers/employees and later reorganizing the company to provide worker's compensation insurance for physicians offices and other selected employer groups.

• Forming the Mississippi Physicians Care Network (MPCN), a statewide physician sponsored preferred provider network (PPO).

• Forming the Physicians Care Insurance Company (PCIC). (Currently being organized and one of several state and county medical society sponsored health insurance carriers.)

The experience of staffing the times and events of these projects and many others that you have addressed through your association will be remembered and greatly missed. On behalf of Phoebe and myself let me say what really can't be adequately expressed. Namely, thank you for being who you are and for letting us be part of your activities for 35 exciting and memorable years.



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Volunteer Lobbyists for MSMA

Under the guidance of Charmain Thompson, Director of Government Affairs for MSMA, MSMAA volunteers joined forces to lobby the State Legislature. Three lobby groups were formed to educate legislators on important issues including the need for a statute of repose, charitable immunity for health providers, and requiring children to wear bicycle helmets on public roadways. Seventeen volunteers were trained in techniques and given direction on the art of direct lobbying. These spouses were also joined by Dr. Chester Masterson of Vicksburg who volunteers his new free time from retirement to bring attention to the needs of the medical community. MSMAA members are encouraged to become actively involved in the legislative process from all areas of the state.



MSMA volunteers review the utilization review legislation recently signed by the Governor. Pictured from left to right are Rachel Aultman, Martha Smith, Charmain Thompson, Susan Pickard and Angela Ladner.



MSMA Past-President Vann Craig, M.D., Jo Waites, MSMAA President Jane Ladner, MSMA Director of Government Affairs Charmain Thompson, Nancy Lindstrom, and Chester Masterson, M.D. make their presence known at a committee meeting on the Statute of Repose.



Brenda Spencer and Charlotte Donnell of Oxford discuss future plans to organize a North MS Alliance at a March coffee.



Jo Waites, Nancy Lindstrom and Rep. Bill Denny discuss legislation addressing the Statute of Repose. Congratulations to these spouses who were successful in their efforts.



Brenda Luethje, President of the Columbia Alliance greets MSMAA President Jane Ladner at their luncheon meeting in March.



In April Homochitto Valley Alliance members hosted the State Officers at the home of Candace Bundgard in Natchez. Pictured are (left to right) Candace Bundgard, Susan Burwell, Gerry Stem and Dale Steckler.

The *Three* most important things you should know about mental health...

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1 **Mental illnesses are real, common and treatable.**

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3 **Insurance discrimination is common and unfair.**

FMC Becomes I. Q. H.: Information and Quality Healthcare

This is probably one of the most momentous articles we have ever submitted to the State Medical Association Journal, as we announce the name change from FMC to I.Q.H., Information and Quality Healthcare.

In 1996, we celebrated the 25th anniversary of the Foundation's existence. Reviewing its history, we made plans for the future, predicting another 25 years of service and growth as we work toward being a recognized leader of health care quality improvement in the state.

In April, you should have received your formal announcement of the name change from the Foundation for Medical Care to I.Q.H., Information and Quality Healthcare. Many of you may have seen the advertisement which also formally announced the name change to the public. Today the emphasis is more and more focused on the prevention and educational aspects of healthcare. We envision physicians, providers, payers and beneficiaries all working together, focusing on healthcare without the hassles and benefiting from data and processes that will help us all better plan for the future. This name change for the 27-year-old organization will enable it to enter the 21st century with a name more easily identified by the various audiences served in the state, as it strives to provide smart solutions to today's healthcare questions.

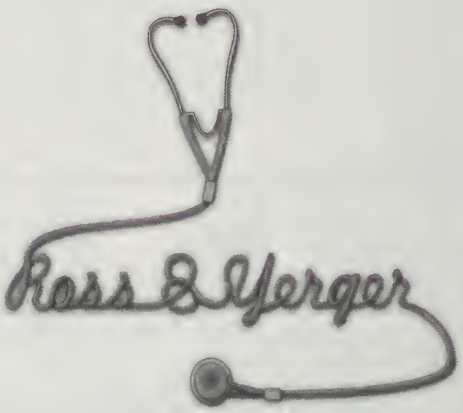
Goals reflect the plan for I.Q.H. to successfully: Monitor health care delivery in order to provide consumer protection and to identify opportunities for improvement; collect, analyze, and share information with our customers so that they may receive, provide, or utilize high quality medical care; and develop strong working relationships among health care providers, the private sector, and the public sector.

In order for this organization to be successful, support and open dialog are required among physicians, hospitals, insurance companies/managed care organizations, government, and consumers of health care. I.Q.H. desires to be of service to our community which is reflected by our non-profit status. We challenge the other participants in Mississippi's delivery of health care to join us in that commitment.

I invite your calls, comments and thoughts, and as always we welcome participation in the future of I.Q.H.

-James S. McIlwain, Jr., M.D., President, I.Q.H.

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New Members

BADR, AHMED E., Born June 14, 1960, Egypt. MD Tanta University School of Medicine, Tanta, Egypt, 1983; neurosurgery residency, same, 1985-90; anesthesiology residency, Vanderbilt University Hospital, Nashville, TN., 1992-96; critical care medicine fellowship, same, 1996-97; elected by Central Medical Society.

BERRY, JAMES MONTGOMERY, Tupelo. Born February 10, 1965, Memphis, TN.; MD University of Mississippi School of Medicine, Jackson, MS, 1992; general surgery residency, Vanderbilt University Medical Center, Nashville, TN., 1992-94 and otolaryngology residency 1994-98; elected by Northeast MS Medical lSociety.

BRIMAH, HAMZA, Greenwood. Born Algeria, April 23, 1965; MD University of Ilorin, Ilorin, Nigeria, 1988; internal medicine residency, Columbia University College of Physicians and Surgeons at Harlem Hospital Center, New York, NY, 1993-96; elected by Delta Medical Society.

COREY, JUDITH L., Gulfport. Born Washington, DC, June 9, 1961; MD Medical College of Georgia, Augusta, GA, 1993; radiology residency, same 1993-96, fellowship in body imaging, Louisiana State University Medical Center, New Orleans, LA, 1996-97; elected by Coast Counties Medical Society.

DESAI, KIRTIDA D., Jackson. Born Surat, India, January 3, 1969; MD Government Medical College, Surat, India, 1992; psychiatry residency, University of Mississippi School of Medicine, Jackson, MS, 1993-97; elected by Central Medical Society.

FAIRBANKS, J. H., Natchez. Born New Orleans, LA, September 26, 1955; MD Louisiana State University School of Medicine, New Orleans, LA, 1983; orthopedic residency, Tulane Medical Center, New Orleans, LA, 1990; total joint fellowship, St. Louis, MO, 1991; sports medicine fellowship, American Sports Medicine Institute, Birmingham, AL, 1997; elected by Homochitto Valley Medical Society.

HORN, GREGORY WADE, Biloxi. Born Arcadia, LA, June 20, 1964; MD Louisiana State University School of Medicine, Shreveport, LA, 1993; ob-gyn residency, Same, 1993-97; elected by Coast Counties Medical Society.

HASAN, SAQIB I., Morton. Born Pakistan, December 28. 1964; MD DOW Medical College, Pakistan, 1990; internal medicine internship, Grant Hospital, Chicago, IL, 1991-92; internal medicine residency, St. Luke's Hospital & St. Louis Regional Medical Center, St. Louis, MO, 1992-94; infectious disease fellowship, University of Tennessee Medical Center, Memphis, TN., 1994-96; elected by Central Medical Society.

MANI-SUNDARAM, DEV A., Jackson. Born Madras, India, February 29, 1960; MD Madras University, India, interned one year, same; general surgery residency, same 1983-86; general surgery residency, MGH Group Hospital, Chicago, IL, 1987-93; plastic surgery residency, University Medical Center, Jackson, MS, 1993-95; elected by Central Medical Society.

MAXWELL, GERALD S., Vancleave. Born Norwalk, OH, September 10, 1956; DO Ohio University College of Osteopathic Medicine, 1994; family medicine residency, Ft. Wayne Medical Program, 1994-97; elected by Singing River Medical Society.

McHUGH, BERNIE G., Hattiesburg. Born Wilmington, DE, January 31, 1957; MD Tulane Medical School of Medicine, New Orleans, LA, 1992; interned one year in surgery department, University of Tennessee Medical Center, Memphis, TN.; neurosurgery residency, same, 1993-97; PGY 5, same, 1997-98; elected by South MS Medical Society.

McSHAN, MAURICE, Jackson. Born Houston, MS, July 17, 1967; MD Howard University School of Medicine, Washington, DC, 1994; internal medicine residency, University of Tennessee Medical Center, Memphis, TN., 1994-97; elected by Central Medical Society.

MEACHAM, ROBERT R., III, Southaven. Born Charleston, SC, December 30, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1994; internal medicine residency, University of Tennessee Medical Center, Memphis, TN., 1994-97; elected by Desoto County Medical Society.

MULLENDORE, WILLIAM, Columbus. Born Cleveland, MS, May 14, 1947; MD Amerian Uni-

versity of the Caribbean, 1991; family medicine residency, Deaconess Hospital, Evansville, IN 1991-94; elected by Prairie Medical Society.

NOWICKI, STEVEN D., Laurel. Born December 4, 1949; MD Wright State University School of Medicine, Dayton, OH, 1983; interned one year, New York Infirmary, Beekman Hospital; orthopaedic residency, National Naval Medical Center, Bethesda, MD1993; spine fellowship, University of Rochester, Rochester, NY, 1997-98; elected by South MS Medical Society.

PETRA, SIMONA S., Holly Springs. Born Romania, January 13, 1966; MD University of Medicine, Tirgu Mores, Romania, 1990; internal medicine residency, Cabrini Medical Center, New York, NY, 1993-97; elected by Delta Medical Society.

PITTS, LANE J., Hattiesburg. Born September 26, 1969; MD University of Mississippi School of Medicine, Jackson, MS, 1995; interned one year, University of Alabama Medical Center, Huntsville, AL; family medicine residency, University Medical Center, Jackson, MS, 1996-98; elected by South MS Medical Society.

RODRIGUEZ, JACK J., Natchez. Born San Juan. PR, September 1, 1964; MD Ponce School of Medicine, Ponce, PR, 1991; internal medicine residency, St Louis University Hospital, St. Louis, MO, 1991-94; hematology/oncology fellowship, same, 1994-97; elected by Homochitto Valley Medical Society.

ROLLER, KEITH ALAN, Oxford. Born April 27, 1964; MD Northeastern Ohio University College of Medicine, Rootstown, OH, 1987; general surgery residency, Western Reserve Care System, Youngstown, OH, 1987-89; anesthesiology residency, same, 1989-92; elected by North MS Medical Society.

SCHIAVI, FRANK, JR., Gulfport. Born Louisiana, November 14, 1934; MD Louisiana State University School of Medicine, New Orleans, LA, 1962; orthopaedic surgery residency, Charity Hospital, New Orleans, 1963-65 and Mt. Sinai Hospital, Miami Beach, FL, 1965-67; elected by Coast Counties Medical Society.

SHORT, JEFFREY K., Hattiesburg. Born Columbia, SC, October 4, 1961; MD Medical University of South Carolina College of Medicine, Charleston, SC, 1988; diagnostic radiology residency, University of Maryland Medical Center, Baltimore, MD, 1988-92; interventional radiology fellowship, Emory University Medical Center, Atlanta, GA, 1993-94; elected by South MS Medical Society.

SMITH, MARY KELLI, Magee. Born Louisville, MS, March 17, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1990; family medicine residency, University of Mississippi Medical Center, Jackson, MS, 1990-93; elected by Central Medical Society.

WELLER, MARIA L., Vicksburg. Born Fargo, ND, June 1, 1964; MD University of North Dakota School of Medicine, Grand Forks, ND, 1990; transitional residency, one year, Butterworth Hospital, Grand Rapids, MI; pediatric residency, DeVos Childrens Hospital, Grand Rapids, MI, 1991-94; elected by West MS Medical Society.

WARD, BRAD ALLEN, Columbus. Born Bryan, Texas, October 29, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1990; neurosurgery residency, University Medical Center, Jackson, MS, 1990-96; elected by Prairie Medical Society.

WHITAKER, DONALD W., Hattiesburg. Born Ohio, July 30, 1967; MD Wright State University School of Medicine, Dayton, OH, 1993; ob-gyn residency, University Medical Center, University of Florida, Gainesville, FL, 1993-97; elected by South MS Medical Society.

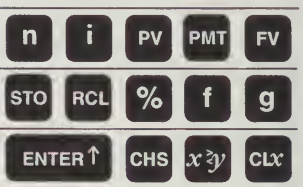
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James D. Hardy, professor emeritus of surgery and former chairman of surgery was among the first group of honorees selected for the Alabama Health Care Hall of Fame. The induction ceremony was held in Montgomery, Alabama. Dr. Hardy, an Alabama native, served as the University Medical Center's (UMC) first chairman of the Department of Surgery until his retirement. His career was marked by historically significant contributions to the field of transplantation and leadership in the world's most influential surgical groups. He led a UMC team that performed the world's first lung transplant in 1963 and the world's first heart transplant in 1964.

Davis Lee Sullivan, M.D. recently passed his certification examination to become a Diplomate of the American Board of Obstetrics and Gynecology. In addition to being published in the early issues of *Obstetrics and Gynecology* and the *American Board of Medical Specialties*, Dr. Sullivan will also be listed in the Directory of Medical Specialties. Dr. Sullivan practices with HubSouth Tower Pavilion for Women in Hattiesburg.

John M. Guice M.D. has joined Hub South in the practice or Urology. Dr. Guice, a native of the Hattiesburg area, attended the University of Southern Mississippi where he completed his undergraduate studies in Biology. He received his Doctorate of Medicine from the University of Mississippi Medical Center. Dr. Guice completed his residency at the Medical College of Virginia in the Department of Surgery, where he also served as Chief Resident of Urology Surgery. His medical affiliations include serving as Secretary/Treasurer for the Mississippi Urological Association, member of the American Association of Clinical Urologists.

Brian P. Johnson, M.D., has joined the staff of Baptist Medical Center, Jackson, specializing in orthopedic surgery. He is affiliated with Mississippi Sports Medicine & Orthopedic Center, Jackson.

Richard D. DeShazo, M.D., recently joined the medical staff at Baptist Medical Center, Jackson, specializing in allergy immunology. He is affiliated with the University of Mississippi Medical Center Department of Medicine, Jackson.

Denzil G. Robertson, M.D., internal medicine, has been named chief of staff at Noxubee General Hospital, Macon.

George Wilkerson, M.D., a neurologist with HubSouth Medical Group in Hattiesburg, recently returned from Washington, D.C. where he participated as a member of an Advisory Board of the "Defense and Veterans Head Injury Program." The Defense and Veterans Head Injury Program is a project under the supervision of the Department of Defense and the United States Congress. The responsibility of the Defense and Veterans Head Injury Program is to devise and implement the optimal evaluation and treatment protocols for active duty military and veterans with head injuries suffered while on active duty. Dr. Wilkerson is one of five members of the Advisory Board. The full committee consists of two active duty military officers, a division chief from VA Hospital, another expert in Neurology and Dr. Wilkerson. The Advisory Board is responsible for insuring that all of the programs regarding head injury in the United States that are under the direction of the Department of Defense are the finest possible and the highest quality. During the presentations, research protocols were reviewed by Dr. Wilkerson and his four colleagues for their scientific validity, their cost effectiveness, and most importantly how their application could improve the quality of life for America's military personnel who sustained injuries while on active duty. Dr. Wilkerson is a Neurologist in private practice with HubSouth Neuroscience Center and has been in practice in Hattiesburg since 1975.

Philip B. Ley, MD, FACS of Jackson, MS, was recently appointed Mississippi State Chair of the American College of Surgeon's Cancer Liaison Program. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Sur-

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

geons. Dr. Ley is a leading member in a national network of over 2,000 volunteer Cancer Liaison Physicians who provide leadership and support to the Approvals Program, and other Commission on Cancer activities. As Mississippi State Chair, Dr. Ley will help select and guide Cancer Liaison Physicians throughout the area in the establishment of local cancer programs designed to improve patient care, and in the implementation of other Commission on Cancer activities. Dr. Ley will provide leadership for the Triad Clinical Cancer Control Program, which is a joint effort of the Commission on Cancer, the American Cancer Society, and the National Cancer Registrars Association. The goal of the program is to establish an effective network of American Cancer Society division leaders, Cancer Liaison Program state chairs, cancer registrar association presidents, and where appropriate, state health department or state cancer registry representatives. These networks will be working to identify cancer control issues, develop strategies, implement programs, and evaluate the effect of these activities at the state and local levels. Established in 1922, the Commission on Cancer, which is composed of Fellows of the College and liaison members representing more than 37 other cancer-related organizations, has approved more than 1,480 cancer programs in institutions across the country. The Commission reviews each institution's cancer program for conformity to their established standards, and encourages participating hospitals to equip and staff themselves so that they are able to provide the best in the diagnosis and treatment of cancer. The State Chairs have also encouraged Cancer Liaison Physicians to stimulate their facilities to participate in, and utilize data generated by, the data collection program of the Commission, the National Cancer Data Base (NCDB). Hospitals receive a call for data at five year intervals. For example, during the seventh call for data, cancer patient information was collected for 1985, 1990, and 1995 to study long- and short-term survival rates. Case counts totaled 232,577 for 1985 (from 501 hospitals); 408,372 for 1990 (839 hospitals); and 689,714 for 1995 (1,227 hospitals).The State Chair cooperates regularly with this program in the dissemination and interpretation of the resultant reports throughout their individual states, which can impact cancer patient care.

Dobrivoje Stokic, M.D., Research Associate at the Mississippi Methodist Rehabilitation Center (MMRC) in Jackson, recently published two papers entitled "Assessment of Corticospinal Function in Spinal Cord Injury Using Transcranial Motor Cortex Stimulation" in the *Journal of Neurotrauma* and "Intracortical Inhibition of Lower Limb Motor Evoked Potentials After Paired Transcranial Magnetic Stimulation" in *Experimental Brain Research.*

Stuart Yablon, M.D., Director of the MMRC Brain Injury Program, made the following presentations: "Botulinum Toxin: Management of Spastic Hypertonia Among Patients with Acquired Brain Injury" and "Emerging Insights Into the Management of Venous Thrombo-embolic Disease Among Patients with Acquired Brain Injury", at the Annual Conference of the Beijing Rehabilitation Medical Association, Beijing, Peoples Republic of China; "Advances in the Treatment of Traumatic Brain Injury: Management of Spasticity", at the International Rehabilitation Medicine Association, Kyoto, Japan.

Julias M. Cruse, M.D., UMC professor of pathology, traced the history of medicine from antiquity to the present when he delivered the fifth Dean Billy S. Guyton Lecture as part of National Library Week activities. This lecture, founded by Cruse, is named for the late Dr. Billy S. Guyton, a dean of the medical school in the 1930s. Dr. Cruse's topic,"The Metamorphosis of Scientific Medicine in the Ever Present Past," discussed the origins of modern medicine from ancient Greece to the technological advancements of the 20th century. Dr. Cruse spoke at length about the founding and leadership of the first American medical school, Johns Hopkins, which laid the groundwork for all future medical training in the country. He also discussed the role of the medical library in medicine, both in the past and in the present. Dr. Cruse, director of immunopathology and transplantation immunology and director of graduate studies in pathology, is the author of more than 250 publications in scholarly journals, 35 books, and is founder and editor in chief of three international journals including *Immunologic Research Pathobiology and Transgenics.* He is also founder and editor of the book series *The Year in Immunology,Concepts in Immunopathology,* and *Complement Profiles.*

Mohammed Alfarawati, M.D., of Greenville, recently received certification as a Diplomate in Pulmonary Disease. Dr. Alfarawati graduated from Damascus University Medical School and completed his internship and residency at Yale University. He went on to earn a fellowship at the University of Mississippi. Dr.

Alfarawati, the medical director of Respiratory Therapy and the Sleep Disorders Laboratory at The King's Daughters Hospital, is a pulmonologist with a special interest in sleep medicine. Dr. Alfarawati is also board certified in internal medicine.

Stephen Mills, M.D., of Brookhaven, presented a slide presentation about sexually transmitted diseases and teen pregnancy at a health seminar sponsored by the Junior Auxiliary of Canton for Canton middle and high school students. About 400 teenagers from Nichols Middle School, Canton Academy and Holy Child Jesus School attended. Dr. Mills, who has made similar presentations to students in Oxford, Grenada and Tupelo, put together the program after discovering the pregnancy of a 12-year-old patient.

Joseph A. Pedone, M.D., cardiologist, and the Pascagoula Public Library offered a free health program, "Peripheral Vascular Disease." The hourlong program described the symptoms and causes of this disease process with particular emphasis on how this disease effects the diabetic patient.

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Robert Irwin, M.D., a board-certified allergist with the Allergy and Asthma Clinic of North Mississippi, spoke on the diagnosis and treatment of allergies at a free educational program presented by the North Mississippi Health Services Community Health Department and the pharmaceutical company Glaxo Welcome.

George R. Bush, M.D. and J. Ken Grafton, M.D., both of Laurel, were recently recertified by the American Board of Family Practice. To receive this certification, the two physicians went to Atlanta, Georgia for exams and had to complete 150 or more hours of continuing medical education in the past three-year period. Dr. Bush has been with Westridge Family Clinic, formerly Boone Clinic, for the past 18 years. He is past president of the Mississippi Academy of Family Physicians, and a board member of the Medical Assurance Company of Mississippi. Dr. Grafton, a native of Laurel, came to Westridge Family Clinic in July of 1984. He is a past chief of staff of South Central Regional Medical Center.

John F. Hassell, M. D., of Laurel, has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians (AAFP), the national association of family doctors. Dr. Hassell has been an active AAFP member since 1976.

Daniel F. Vial, M.D., has joined the medical staff of South Central Regional Medical Center as a vascular and interventional radiologist. He recently completed a fellowship in cardiovascular and interventional radiology at the University of Oklahoma Health Science Center in Oklahoma City. He completed his residence in diagnostic radiology, at Texas A&M University/ Scott & White Hospital in Temple, Texas where he was also chief resident. A native of Hanville, Louisiana, Dr. Vial's undergraduate and medical degrees are from Louisiana State University. He is board certified in radiology and is a member of the American College of Radiology, the Radiological Society of North America, the American Roentgen Ray Society and the Society of Cardiovascular and Interventional Radiology.

Jack Herring, M.D. was the recipient of the Outstanding Citizen Award presented by the Magee Chamber of Commerce during their annual banquet.

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Membership Benefits

Representation, advocacy, public relations and support of professional ethics are some of the reasons MSMA exists for its members. These are the intangible but important benefits of membership which MSMA seeks to provide through member participation. There are also more tangible benefits which the association provides its members. Illustrated here are the MSMA-sponsored programs for such member needs as insurance and practice management support. These programs are listed below.

MEMBERSHIP HOTLINE
The MSMA provides a toll free WATS for any member to call to inquire about medical matters and programs of the association. Inquiries about AMA programs and policies can also be made over a membership WATS line.

MEDICAL OFFICE SUPPLIES
MSMA members can save up to 40 percent on medical office supplies through "AMA Purchase Link". Under this program discounted medical, surgical and pharmaceutical products are available from Henry Schein, Inc., the largest nationwide distributor of such products to physicians' offices.

THIRD PARTY PAYOR LIAISON
MSMA conducts liaison with Travelers Medicare, Medicaid and other third party payor programs on behalf of its members. Individual claim problems, as well as general policy matters, are important aspects of this liaison. For further information call Jackye Wiebelt at MSMA.

HEALTH INSURANCE
MSMA members who are organized as PAs and wish to provide health insurance coverage for their employees are eligible to participate in a self-insured 501(c)(9) trust sponsored and administered by a subsidiary of the association. For information contact Jackye Wiebelt at MSMA.

WORKERS' COMPENSATION INSURANCE
The MS Physicians Insurance Company (MPIC) is affiliated with MSMA and currently provides workers' compensation coverage to physicians' offices at the lowest rates available. MS law requires every employer with five or more employees to obtain such insurance. For further information contact Gusta Stanford at MPIC.

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Through an arrangement with the AMA Department of Practice Management, MSMA periodically conducts practice management workshops for physician's office personnel. These workshops cover a broad range of topics from CPT-IV coding to patient surveys. For further information call Jackye Wiebelt at MSMA Diversified Services, Inc.

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Based upon sponsorship by medical associations in many states and its nationwide network, IC System is endorsed by MSMA to perform debt collection services for offices and clinics of member physicians. IC System has a proven track record as a debt collection service. For further information call MSMA.

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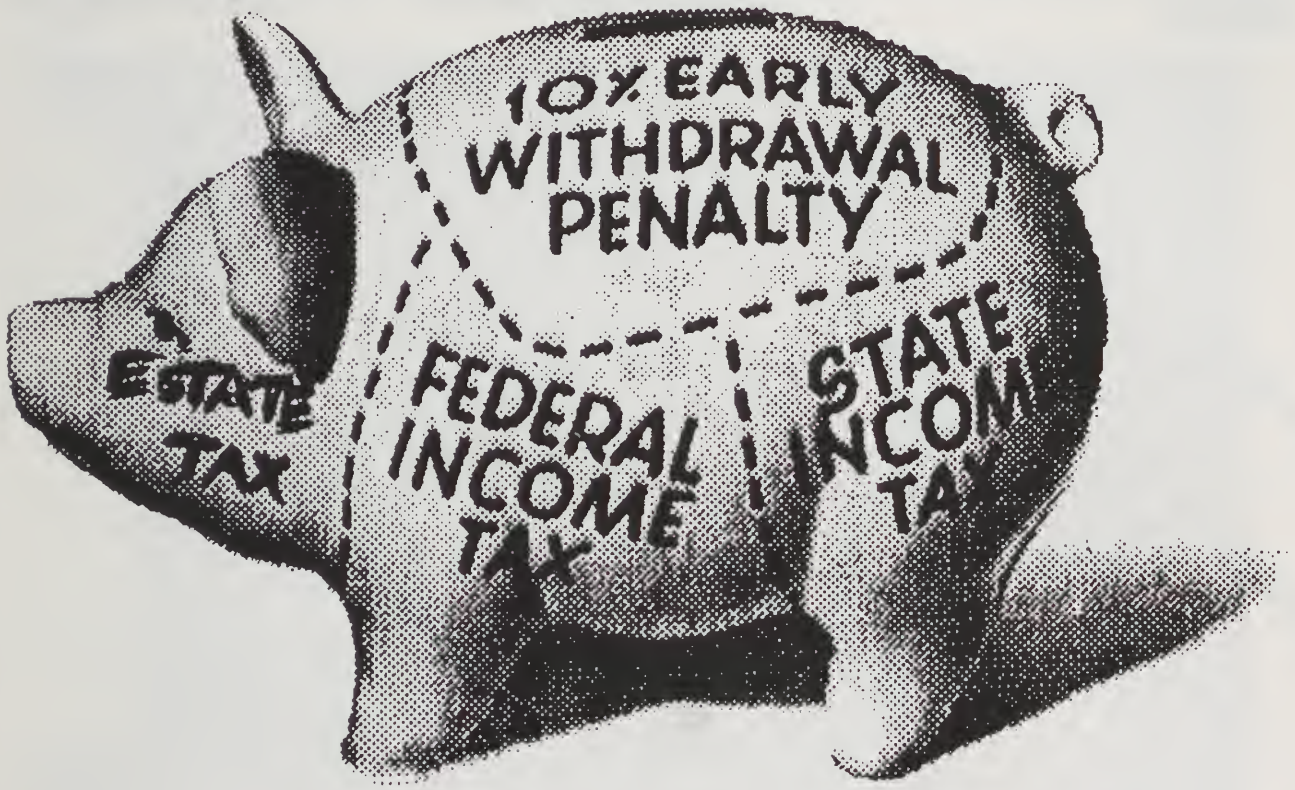
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About the cover:

This photo, "Andrew Looks at Nolan's Very First Fish" was taken by their grandfather, Ralph L. Brock, a retired family practitioner in McComb. The twins were one month shy of their third birthday. Dr. Brock noted after Nolan caught the fish, after less than two minutes of trying, he lost interest in fishing and started playing with his baseball. He felt he had accomplished all that he needed to do with fishing. The twins belong to Jim and Brenda McIntyre.

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Amnioinfusion-Induced Malpresentation

Joseph F. Washburne, M.D.
Suneet P. Chauhan, M.D.
Everett F. Magann, M.D.
James L. Moore, Jr., M.D.
John C. Morrison, M.D.

Abstract

Amnioinfusion is a valuable and common intrapartum procedure for the relief of cord compression and to dilute thick meconium. Like most procedures, it is not without risk and we report a case of malpresentation following amnioinfusion. Intrapartum fetal demise occurred after malpresentation during amnioinfusion resulting in a change of fetal presentation from vertex to unrecognized shoulder presentation. Further study is needed regarding changes in volume of amniotic fluid and saline as well as intrauterine manipulation and the effect on fetal presentation. Careful attention must be paid to infused volumes during amnioinfusion.

Introduction

Saline amnioinfusion has been demonstrated to be effective in preventing and relieving repetitive variable decelerations from oligohydramnios.[1] Amnioinfusion has been associated with a lower cesarean section rate for fetal distress and an improved metabolic state in infants of patients with preterm premature rupture of membranes.[2] However, the procedure is not without risk. Increased intrauterine pressure and iatrogenic hydramnios have been reported following amnioinfusion.[3,4] However, there have been no reported cases of iatrogenic malpresentation associated with this procedure. We report a case that illustrates this unfortunate outcome.

Case Report

A 21-year-old woman, gravida 2, para 0, abortion 1, at 28 weeks' gestation presented to University Hospital in advanced preterm labor. The patient had a negative review of systems and her obstetric history was significant only for a prior spontaneous abortion at 18 weeks' gestation. Upon admission to labor and delivery the physical exam was normal with a fetal heart rate of 140 and a cervical exam revealing 5-cm dilation, 100% effacement, and -3 station. An ultrasound examination was performed which revealed an infant with corresponding gestational age and vertex presentation.

After approximately two hours of observation, the patient had spontaneous rupture of membranes with clear amniotic fluid. A fetal scalp electrode and intrapartum pressure catheter were placed without difficulty and the vertex was reconfirmed. Moderate variable decelerations were noted, and an amnioinfusion of 500 cc normal saline was begun. Improvement was noted, and after completion of the first amnioinfusion, the second was begun.

Approximately 60 minutes later, the nurse notified the labor and delivery physician that she could not obtain a fetal heart rate by auscultation. A vaginal exam was performed and revealed a questionable shoulder presentation with palpable small parts in the vagina. There was no evidence of prolapsed cord. A repeat sonogram and fetogram confirmed a shoulder presentation and intrapartum death. Pitocin augmentation was begun and the patient subsequently delivered in the shoulder presentation, a non-viable female infant weighing 1080 g.

Discussion

Amnioinfusion for the prevention and/or reduction of cord compression in labor has become an accepted practice. Its value in the intrapartum course has been reaffirmed in prospective trials.[1,5] Few complications with this procedure have been reported. However, the present case emphasizes the importance of careful attention to the volume and rate of the amnioinfusion, particularly in premature gestations.

Rapidly infused volumes of fluid into the uterine cavity have been associated with acutely increased intrauterine pressure.[3] In this particular case, we speculate a rapidly infused bolus was placed into a uterus where the fetal head was well applied, creating a closed system. Thus, a ball valving effect of the fetus took place where the vertex was actually floated out of the pelvis. The infused fluid was allowed to thus escape rapidly, reengaging the fetus in a compound presentation. Unrecognized oblique lie with fetal part filing the pelvic inlet carries a high risk of fetal morbidity and mortality.[6,7] This situation can be avoided with careful attention to the amount and rate of fluid instilled as well as continued observance of the fetal heart rate pattern. Adhering to these principles should prevent fetal compromise in an otherwise relatively safe procedure.

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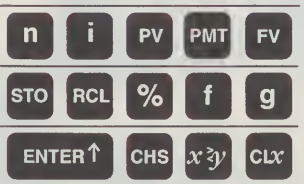
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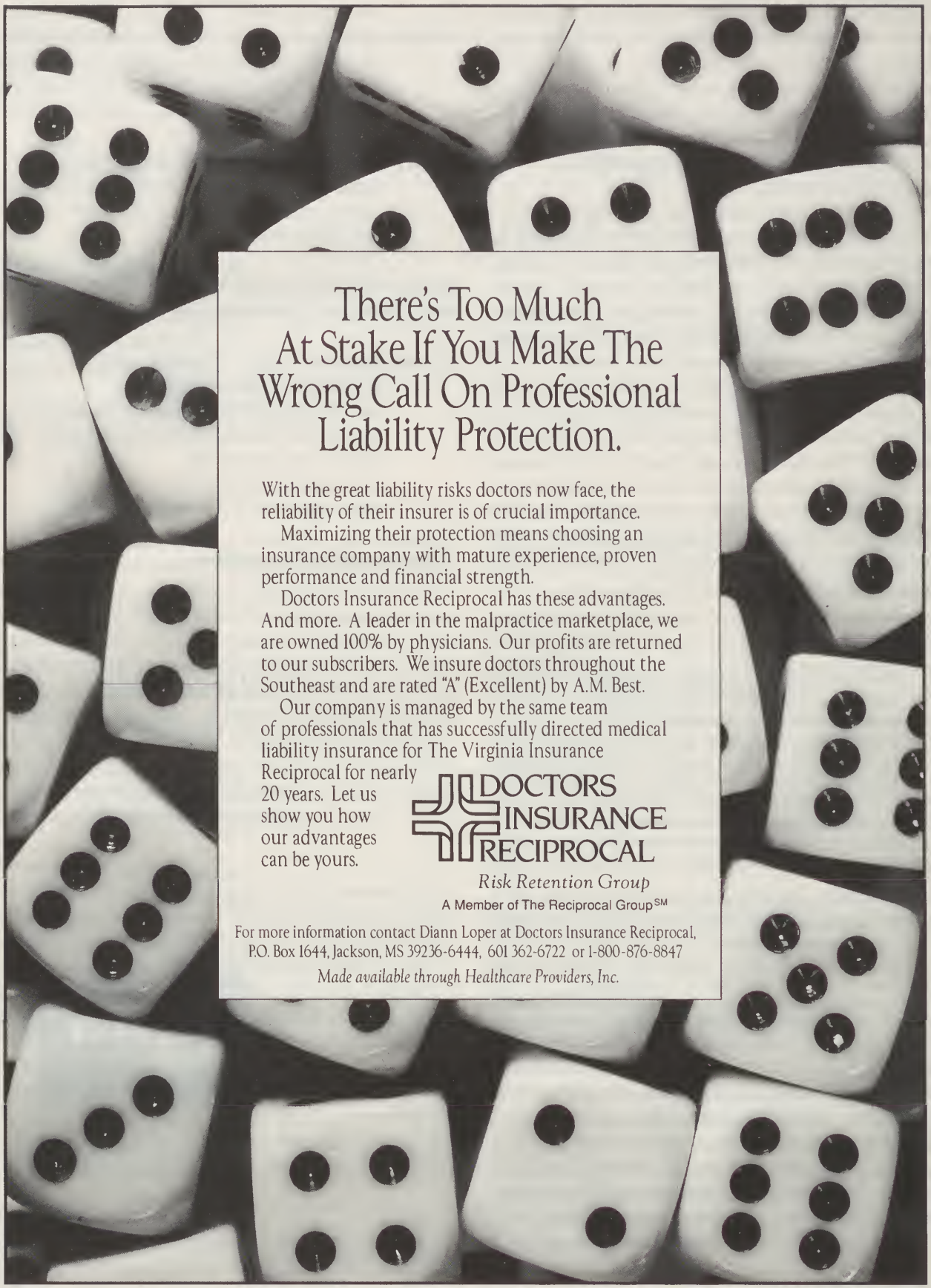
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A. AMA began developing combination codes in 1994. Based on my understanding of AMA guidelines, when you give two separate injections, you would report the services as two separate procedures. The combination codes would only be used if you had purchased a combined drug and given a single injection.

At the AMA convention in Chicago last November, AMA Coding and Nomenclature stated the new CPT code for MMR and varicella was developed to provide offices a means to report the service when the drug became available in the fall of 1996.

Q. Sometimes we have patients who have to be admitted to observation following ambulatory surgery for monitoring before they can be discharged. The resulting problem is finding a diagnosis to support the additional service. Should we use V codes? Any suggestions?

A. In coding a diagnosis, you may only code to the highest degree of certainty established by the physician's documentation. Therefore, if the patient was admitted due to nausea, increase in blood pressure, fever, etc., it would be appropriate to use these as principle diagnoses. Symptoms necessitating observation should be coded and sequenced according to acuity.

If the documentation does not support a sign or symptom, you would need to use a V code as the diagnosis. Some applicable V codes are as follows:

V71 Observation and evaluation for suspect condition. (Code to the highest level of specificity)

V67.0 Follow up exam after surgery

It should be noted that many carriers do not consider V codes as sufficient justification for admission to observation and will deny the service as medically unnecessary. Whenever possible based on the documentation, code the sign or symptom resulting in the patient being admitted to observation.

CODING TIP

CPT provides important clues for correct code usage through conventions and explanatory statements. CPT explains the conventions and their usage in the introduction section. This section should be reviewed by all coders and providers of service upon receipt of the new editions of CPT with periodic review.

Do you have a question you would like answered in the Journal? Send your inquires to Wanda L. Adams, CPC, 3280 Lupine Drive, Arnold, MO 63010. Please include your name and phone number should additional information be required.

* CPT codes and descriptions, copyright 1997, American Medical Association

Wanda L. Adams, CPC, Healthcare Consultant and published author. Founder and past president of the St. Louis Chapter of the AAPC. She currently serves on the National Advisory Board of the AAPC and the Editorial Panel of Code Facts, a Medicode publication.

1997-98 President's Address
MSMA 130th Annual Session House of Delegates
Grand Hotel Biloxi - May 14, 1998

May You Live in Interesting Times

"May you live in interesting times," some of you have heard me say this from time to time. In western philosophy this probably means may your life be happy and exciting. In oriental philosophy, it is a curse! I am not sure just what it has meant for me this year. To say the least, it has been an interesting year.

It all began last May, when I was installed as your President. I felt pretty good. I was your leader. I was wonderful. I handled a few routine problems - with the help of the staff of course. I did a good job. I was tremendous. I went to the AMA annual meeting in June. The past President for Florida asked at the OSMAP meeting for suggestions of what to do with an insurance shell from their failed HMO. I went over to him after the meeting and told him MSMA's success story about our untimely start of an HMO. It's decrease in stock value from $20 to $9.50 a share. And how, with the leadership of David Steckler, we converted it to a company that sold workers compensation insurance and the stock value climbing to over $25 a share. Me, from Mississippi, giving Florida advice! I was Superman. You look in the mirror each morning and say to yourself, "I'm wonderful. I'm tremendous. I'm Superman." Pretty soon you start believing that stuff.

I got on the plane to come home, and the flight attendant asked everyone to buckle their seat belts for departure. I didn't need to do that. After all, I'm wonderful, I'm tremendous, I'm Superman. I can fly. I don't need a seat belt.

The flight attendant came down the aisle checking everyone. She noticed that my belt was not fastened, and requested that I fasten mine. I told her I didn't need a seat belt. I was wonderful, I was tremendous, I was Superman. She said, "Well, Superman can fly without an airplane, Fat Boy. Buckle your seat belt!"

There is always someone to bring you back to reality.

Reality is that there is too much intrusion from third parties, especially the "O's", that cause us to become hired hands of large competitive corporations and have inadequate authority in the decision making processes of our patients. Many physicians have become discouraged and feel, more in sorrow than in anger, that the spiritual calling and satisfaction of being a physician has declined immeasurably. It's the economic pressures of our transformation from a cottage industry of solo physicians to a business of groups of physicians that are causing this!

Reality is that those same economic pressures can be brought to bare for the benefit of the caring and popular physician. Any of the "O's" will tell you that an employer will dictate to them that they must include Dr. Y and X hospital in their panel because most of their employees go there, and the plan will not be accepted without them.

Reality is that the Health Risk Industry - a nice new name for an HMO - is more than willing to discuss problems, both those real and those perceived with us. These discussions have been fruitful in bringing forth a standardized credentialing form that will be presented to the insurance industry as the form they MUST use instead of each one having their own separate form. These discussions have also brought about contract changes to our advantage by regulation rather than legislation.

Reality is we have not learned very much about the



H. Vann Craig, M.D. and his wife, Elizabeth at the President's Dinner

political process in the past 125 years. If you take the time to read the excellent summary of our past proceedings by Karen Evers in the 150th Anniversary issue of our MSMA Journal, you will see we have always had problems relating to the Legislature. Even though we have had a successful Legislative year with the passage of a seven year statue of repose, the UR law that requires physicians doing utilization review to be licensed in Mississippi and subject to discipline by the Board of Medical Licensure, and stopping the Optometry scope of practice expansion bill in committee, we still have a long way to go. I do not understand why Physicians are reluctant to become involved in a process that effects our livelihood on a daily basis. We must become involved. Physician licensure began in Venice in the early 1500's. This defined the practice of Medicine. Ever since then, those outside have been trying to get a piece of the action. Legislatively, they only have to win once. We have to win every time. The time has come for Organized Medicine to become active rather than reactive. If some para-medical group wants to expand its scope of practice, we should introduce an amendment to place that expanded scope under the Board of Medical Licensure. We may not get very far with this the first few times we introduce it, but we will, at least, serve notice that if you want to act like a physician, you will have to measure up to our standards. Nurses who wish to practice independently should have to pass the specialty board exam in internal medicine, pediatrics, obstetrics, or anesthesia. The time has come for Medicine to draw a line in the sand and say, "If you want to be a Physician, go to medical school." We owe this to our patients and I call upon the Council on Legislation to strongly consider this position.

Reality is that this is the most exciting time to practice Medicine. Even with all the hassles and hoops of care management, the good old days weren't so good after all. Today we have much more effective medications that cure or treat diseases we once could only diagnose and say "I'm sorry." Diagnostic technologies that are non or minimally invasive allow us to see the human body as never before. Improvements in anesthesia and surgery have shifted care to the ambulatory or overnight setting. Much has changed from when I began the study of Medicine. I'm sure you can think of other wonderful improvements that have occurred that make these the good old days.

Now, as president of your association, I declare that there will be good weather for the next four days. I did this once before when I was Speaker of the House. Buster McVay told me I couldn't do that, but I can because I'm wonderful, I'm tremendous, I'm Superman.

Thank you for the privilege of serving as your President. **-H. Vann Craig, M.D.**

Address to the House of Delegates
Percy Wootton, MD, President, American Medical Association
MSMA 130th Annual Session
Grand Hotel Biloxi - May 14, 1998

Moving Medicine Ahead – By Working Together

Good morning and thank you for the warm welcome.

Before I begin today, let me thank you also — not only for your kind invitation — but also for all that you do on behalf of organized medicine. There is so much good that you do, it's hard to know where to begin.

First of all, let me congratulate you on your status as a unified state.

At a time when there is so much that has the potential to divide medicine . . .A time of continuing change in the marketplace and Washington . . .A time when it is more important than ever that we speak with a single voice – You provide a shining example of unity.

As a unified state, you demonstrate your commitment to organized medicine. And we at the AMA are so grateful to you for that. In fact, we wish every state would follow your example.

And not only do you practice what you preach, you send your people out into the field, to carry the word about organized medicine throughout the country.

We will never forget Dr. Sidney Graves, who for so many years chaired the Mississippi delegation. Dr. Graves was a shining light on virtually every level of organized medicine. I know he was a mentor to many of you. We shall miss him.

Fortunately there are other Mississippians who follow in Dr. Graves' footsteps. Your own Dr. J. Edward Hill, my esteemed colleague on the AMA Board of Trustees, and chair of our AMA Task Force on Membership. Your Doctors Candace Keller and Jim Fuller, who serve so diligently on the AMPAC Board. Your own Dr. George McGee, who, after his years of involvement in the Young Physicians Section, is now vice-chair of the AMA's Federation Coordination Team and incoming chair of the AMA's Council on Long Range Planning and Development.

And I would be remiss here not to acknowledge the many years of good work Charlie Mathews has dedicated to your association. Congratulations, Charlie, on your retirement. We wish you the best.

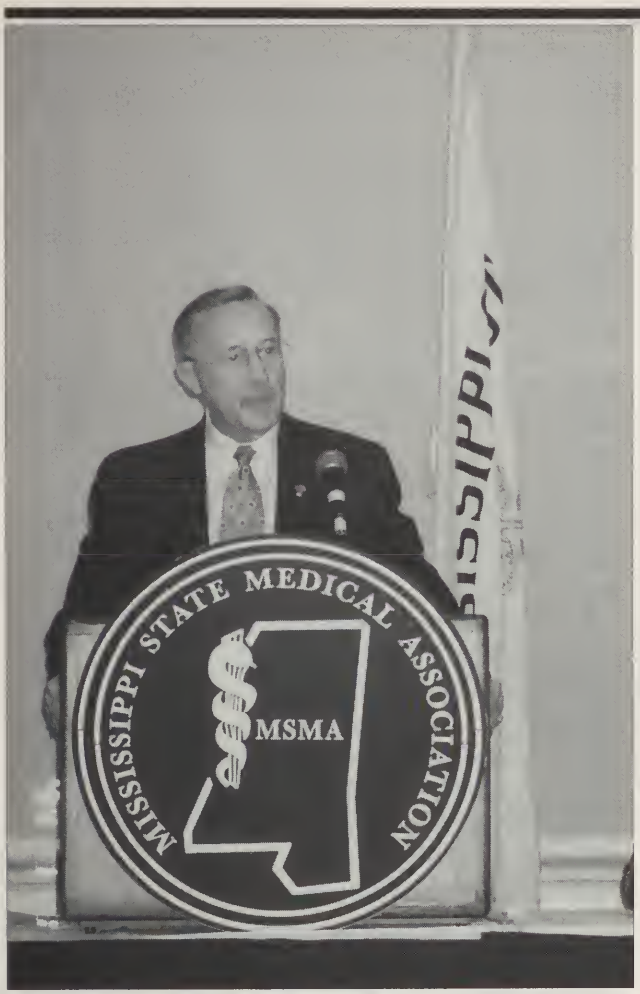
And we'll see you at the AMA Annual Meeting where I hope you are all aware Charlie will receive the Medical Executive Achievement award in the opening ceremonies on June 14.

And congratulations, too, to Bill Roberts, who will be replacing Charlie as executive director. Bill, as you know, used to be responsible for Medical Society Relations at the AMA. So he is well-connected with our AMA staff both at headquarters and Washington, D.C. and well-connected with the issues organized medicine faces today.

The truth is, all of you deserve congratulations. All of you gathered here, through your participation in the Mississippi State Medical Association, are giving the patients and physicians in this state a needed advocate and our AMA a needed ally in our on-going battle to improve our health care system.

The poet Robert Frost once said there were two kinds of people in this world. Those willing to work and those willing to let them.

Your presence here today tells me which group all of you belong to. Your participation at this meeting shows



Percy Wootton, M.D.
President, American Medical Association

your willingness to take on the responsibility and accountability that organized medicine requires. And, on behalf of our AMA members and Board of Trustees, I thank you for your support and encourage you to keep up the good work.

A few weeks ago, we saw a good example of what organized medicine can accomplish when we work together. I'm talking, of course, about last month's Federation meeting on E&M Guidelines.

About 300 leaders of organized medicine, including your own Dr. Jim Waites and Jackye Wiebelt, came for the meeting.

And here's what we accomplished.

First, an indefinite extension of the current grace period your AMA won for you last December. With the 1997 guidelines essentially on the scrap heap as a lasting document, and with the chance now to create a new set of guidelines that make sense for medicine.

Next, a pledge from the government to responsibly pursue its concerns about fraud and abuse while making a clear distinction between compliance and criminalization. And removing the threat and the fear for good physicians.

And finally, HCFA has agreed with us on the need to establish a testing process for the guidelines, and to follow it with added revisions and a strong effort for education.

Those are all key victories for medicine and physicians and a good example of what our AMA and Federation members can accomplish when we work together.

But the news gets better.

Because last week, Congress showed that it, too, is getting the message. On May 4, a resolution went forward with the Senate, expressing that "sense of the Congress" as it's called, on E&M documentation guidelines.

Here is what Senator Robert Torricelli of New Jersey had to say as he introduced the resolution: "Rather than improving the quality of patient care, the new E&M guidelines have



The Mississippi Delegation to the American Medical Association escorts AMA President Percy Wootton, M.D. to the rostrum.

caused patient care to suffer. The resolution I rise to submit today expresses the sense of Congress that HCFA should postpone its plan to implement the documentation guidelines and continue consultation with physicians' organizations on how to reduce the complexity of E/M guidelines."

We couldn't agree more, Mr. Senator.

And working with leaders from our state, county and specialty societies, we are committed to developing a better set of guidelines for physicians. And for patient care. That's a promise.

Already a "new framework" for replacing the current guidelines was unveiled at last month's meeting and it was well-received by participants.

Until the new guidelines are developed, however, the 1994 guidelines, or 1997 guidelines if you prefer them, remain in force. So, keeping good records will still be important.

What we heard from the participants in the Federation meeting, HCFA, the OIG, federal officials and Federation members alike, is documentation is important. And, some kind of documentation, of course, is here to stay. After all, you can't very well spend the taxpayers' dollars without some kind of accountability.

But the most important thing is this: Nothing more is being demanded without physicians' voices being heard.

The extension by HCFA is indefinite, but not infinite. And while I can't tell you exactly when the new revised guidelines will be implemented, I can tell you the next steps the AMA will be taking. And we're asking you to take them with us.

First of all, the results of the work from the fly-in will go directly to the CPT Editorial Panel for their meeting this month. And they will do the hard technical work of putting that input into action.

Next, the results of CPT's efforts will be sent out for feedback, which we hope to receive by the end of July. The goal is to give specialties and all physicians an opportunity to respond, Federation members and others. We're even putting a copy on our AMA Website. In other words, we want to hear from as many physicians as possible.

At the same time, a copy will be sent to all AMA Delegates in preparation for an open forum at the Annual Meeting in June, where we hope to have HCFA with us again.

After that, the CPT Editorial Panel will make added revisions based on all of these comments. Our goal is then to have a substantially improved product that will be ready for pilot testing.

But the process doesn't stop there. Pilot testing will show us where further changes need to be made. And then, and only then, we will begin the process of education for grassroots physicians and for carriers.

I think some of the most encouraging news we heard from HCFA at that meeting was their pledge to continue to work with us, right through the education process. And that they understand that it is as important to educate carriers as physicians.

Because patient care is strongly based on that very personal interaction between patient and physician, we need to make sure the final guidelines take that into account.

And that everyone involved in the process understands that patient care is not a black-and-white issue – and physicians need to be able to make decisions without fear of unnecessary hassles or sanctions.

While I think what we have accomplished, with and through the Federation, is outstanding, there is important work ahead of us. But together, organized medicine is getting the job done. That's not really surprising, because this is what happens when we work together. This is what being a Federation is all about. It is the work we do as a profession, working in partnership with our Federation on behalf of patients and to strengthen and maintain our profession, that sets medicine apart.

And rest assured, the E&M Guidelines is just one area where your AMA is working with and for patients and physicians.

Another such area is the new National Patient Safety Foundation at the AMA. Created to ensure safe delivery of health care services to all patients in all settings, the National Patient Safety Foundation is a multimillion dollar, not-for-profit initiative aimed at eliminating preventable errors from occurring in our medical workplaces.

It is based on the simple premise that any preventable error in the medical workplace is one mistake too many and when a patient is harmed, it is not enough for the system to simply say, "We're sorry."

In this age of advanced technology, we need to do more to prevent medical errors from happening in the first place. And that is the focus of the Foundation.

Specifically, the Foundation's goals are to:

- Identify real and potential risks in our complex health care system;
- Analyze human and/or organizational errors that may lead to patient injuries;
- And, implement responses to help physicians anticipate potential risks and prevent patient injury.

Because even though medicine in this country is

extraordinarily safe already, we know that errors can and do occur, no matter how careful we are, or how many safeguards we build into the system.

By acknowledging that fact up front, we can open lines of communication between our health care institutions, physicians who work in them and the experts in the field who can help us eliminate preventable medical errors from our workplaces.

And, replace what can be a culture of blame with a community of trust, the most important element in the patient-physician relationship that has always been medicine's first priority.

The E&M Guidelines. The National Patient Safety Foundation – These are outstanding ways in which we can move medicine forward – by working together to protect our patient-physician relationships.

By giving patients and physicians back their autonomy – And by making sure that physicians and patients, not politicians, have the final say in health care decision-making.

And yet, even these are just a few of the important issues our AMA is addressing on your behalf.

I hope now that all of you, who represent the unified state of Mississippi, will work with us in the days and months ahead to see that these and our other important issues bear fruit for our patients and our profession.

Issues like the fight to save Medicare for future generations, tackling unfair managed care contract provisions, and shining our light on important ethical issues like quality care at the end of life and genetic engineering.

Because in order to succeed, organized medicine must work together. And that is truer than ever in these changing times.

Yes, we are accomplishing many good works. But there is still so much that lies ahead. So many other issues need our attention and our actions.

Our commitment to quality . . .

The future of our profession . . .

And the patient-physician relationship.

This is what we stand for.

And today more than ever, it is important that we stand united.

For as united we stand, this is how we will always be.

Physicians dedicated to the strength of our profession.

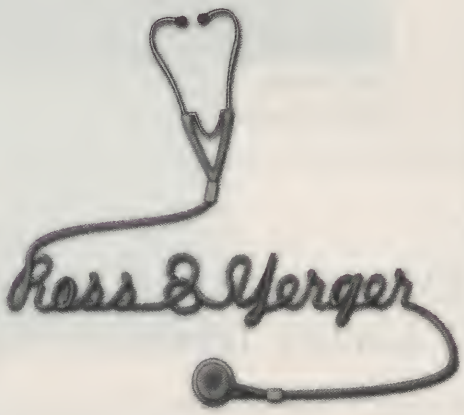
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As your President, I am proud to stand with you – and for you.

And, for our, A-M-A.

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Left to right: *AMA Federation Relations Representative Mike Flesher, AMA President Percy Wootton, M.D.; Jane Wootton, Elmo Gabbert, M.D. and Jean Hill.*

WHEN YOU NEED TO BE SEVERAL PLACES AT ONCE, ISN'T IT A RELIEF TO KNOW YOUR BANK WILL BE THERE, TOO?

The frantic pace of everyday life doesn't leave a lot of time to get to the bank. No problem... *if* you rely on the convenience of one of the state's largest banking networks. Trustmark has more locations in the places where you need us most. We have Trustmark Express ATMs throughout the state. And 130,000 ATMs around the world through our GulfNet and CIRRUS® affiliations. Plus, Trustmark's Express Check debit card gives you purchasing power wherever MasterCard® is accepted, letting you pay by check without writing one. So, next time you're worried about getting to the bank, relax. Whether you're headed ACROSS TOWN or ACROSS THE STATE, there's one bank you can trust to be there: TRUSTMARK.



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1998-99 MSMA President's Inaugural Address
MSMA 130th Annual Session House of Delegates
Grand Hotel Biloxi - May 17, 1998



MSMA Executive Director William F. Roberts holds The Bible while Chairman of the MSMA Board of Trustees Julian Henderson, M.D. administers the oath of office to 1998-99 MSMA President Michael H. Carter, Jr., M.D.



Standing in front of this microphone I'm reminded of a story a patient once told me.

Years earlier, he had lost his larynx to cancer and had to speak using an electrolarynx. You know, the little microphone-like device that some laryngectomy patients use to communicate.

As an ENT surgeon I've cared for dozens of patients who use them, all showing great courage and grace in the process.

But this particular patient showed more than most because despite his physical setbacks he always found humor in life's funny moments.

He told me about one such moment. It had occurred one day when he was out in the yard, talking with his neighbor next door.

They had been visiting for several minutes when he noticed his neighbor's yard man staring at him. My patient didn't say anything because he had seen people stare before. But later that day, his neighbor came over and told my patient that he had really confused the yardman.

My patient said, "Really, how so?"

"Well," the neighbor said, "He was watching you use your electrolarynx and, for the life of him, he couldn't figure out how the thing worked."

"So, I explained to him that you had had surgery for throat cancer and that you needed it so you could talk to people."

The neighbor said the yardman just looked at him for a few seconds, still confused, and then said, "How do that thing know what he want to say?"

Standing here in front of this microphone — looking out at all of you — I'm wondering the same thing — how in the world does this thing know what I want to say this morning?

But seriously, I'm not too worried because I know exactly what I want to say today. And let me start by thanking all of you, my MSMA colleagues, for this great honor. I am humbled by the confidence and trust you place with me today and I will work hard to live up to it.

Of course, I wouldn't be up here at all if not for some very special people. And, I want to thank my wife and best friend, Mary Rose, and my two children Claire Noelke and Walker Carter.

Walker is on a business trip in England and couldn't be here today, but Mary Rose, Claire and her husband, Hal, did come over from their home in San Angelo, Texas.

Mary Rose, would you and Claire and Hal stand up? And, it's a very special pleasure today for me to introduce my parents, Mike and Lucy Carter. What a wonderful treat to be able to share such an occasion as this with my parents!

We all know how hectic and crazy this profession of ours can be at times, all the understanding, accommodations and support that we need to make it work. I am the beneficiary of much more love and unselfish consideration than I can ever repay my family and I thank you.

I also want to thank one other special person, a thank-you on behalf of all of us here and the rest of our members to Charlie Mathews.

For many years, Charlie has been the backbone of this association. Charlie, I hope you know how much we all appreciate your work on behalf of our profession and all our members. Thanks so much.

For those of you who don't know me, I'm an ENT surgeon from Greenwood. People up there tend to be more interested in catfish and duck hunting than the rest of us but their health care problems are really pretty much the same. And though the Delta is not the wealthiest part of our state, the people there are just as appreciative of the care we provide them as anywhere else I've ever been and I've been privileged to serve them for the past 21 years.

I'm also privileged to have been a member of MSMA since 1977. For those of you who have trouble remembering just how long ago that was, let me jog your memory.

A fellow with my last name was in the White House...many of us were waiting in long lines to buy our gas...and Saturday Night Fever, discos and bell-bottom pants were all the rage.

Of course, our medical landscape was quite a bit different, too. Managed care was largely a "West Coast" phenomenon...HMOs were still a novelty for many physicians...and medical issues that generate so much interest today, like AIDS and the human genome project, were not even blips on our radar screen.

MSMA has seen its share of changes as well. When I first joined this organization lack of malpractice insurance was the hot issue. And, we had 1600 members and dues were $125 a year.

Today, thanks to MACM, perhaps MSMA's most successful project to date, we have that malpractice insurance. Our membership is over 3,000 strong. And dues...well, they're a bit more, but still a good value.

Think of all we have accomplished in just the past year alone. Working together, MSMA and its members



1998-99 MSMA President Michael H. Carter, Jr., M.D. and his wife, Mary Rose.



Left to right: *MSMA Immediate Past-President H. Vann Craig, M.D.; 1998-99 MSMA President Michael H. Carter, Jr., M.D. and MSMA President-Elect W. Briggs Hopson, M.D.*

have scored important victories in the areas of:

- Tort reform
- Health insurance reform, and
- Initiation of a statewide Trauma Care system

And I want to extend my thanks and congratulations to my predecessor, Vann Craig, for all his leadership in addressing these important issues during the past year. Vann, we couldn't have done it without you.

While it's sometimes fun to look back and reflect on the past, I've spent more of these past few days thinking about the future — And the important work facing MSMA, and all of us, in the days and months ahead.

So with that in mind, let me share with you a couple of initiatives that I am targeting as priorities during the next year as your president.

First, I am asking for your help in taking our Mississippi's Physicians Care Network to the next level. To move this program from a successful health care network to a physician-owned and operated health insurance company — A network and carrier that Mississippi patients and physicians can have complete and total confidence in — A network and carrier that can set the standard for health care excellence in today's marketplace.

Now, if that wounds ambitious, it is. The good news is we're not starting from scratch. Because since its debut in 1994 — MPCN continues to surpass our expectations.

Today it covers over 130,000 individual patients and includes a network of over 2,600 Mississippi physicians, 80 hospitals and a long list of ancillary providers, medical services and equipment suppliers.

A year ago, this House of Delegates expressed interest in building on this success. Specifically, you asked the Board of Trustees to investigate the possibility of MPCN forming its own insurance company.

We have done that — and now we are asking for your help in taking the next step. But let me warn you — it's a big one.

Estimates from our consulting firm in Dallas say we need an initial capital base of $15 million dollars to make it work. Now, that's a lot of money — and it won't be easy meeting this challenge.

But I think it's worth it. And let me give you just one reason why.

His name is Mr. Taylor and he's a patient of mine. Mr. Taylor came to see me a few years ago, complaining of hoarseness. I examined him and noticed a small lesion on one of his vocal cords. I scheduled an examination and biopsy. Unfortunately, the bump turned out to be cancer.

I brought Mr. Taylor in, told him the bad news, and discussed his treatment options with him. And the options were really just two — he could undergo primary radiation therapy...or he could have surgery — a partial laryngectomy.

The prognosis for both these options was good and Mr. Taylor opted for surgery. A few days later I performed the surgery and it was a success. The tumor had been removed completely, and he maintained a good, though lightly hoarse, voice.

But patients like Mr. Taylor are at an increased risk for developing a second primary tumor, so he and I weren't completely out of the woods.

But for five years, things went along well...I got him to stop smoking...over time, his monthly visits became annual visits.

And it was during one of these annual check-ups, about five years after the initial surgery, that I detected a bump similar to the earlier one, but on the other side of his larynx.

The discovery was distressing for both Mr. Taylor and me. As medical students, we're told to keep an emotional distance from our patients, not to become too attached. But when you treat a patient long enough and share with him the ups and downs of cancer you become attached, no matter what anyone says.

Mr. Taylor and I both knew what had to be done, so my office called his insurance company to get the necessary approvals for another round of biopsies and follow-ups.

But approval for these test never came. It seems his employer had switched insurance carriers and my name was not on the new roster of providers.

Instead, the carrier told Mr. Taylor that he would have to drive all the way to Memphis to get the care he needed. From a physician — neither one of us knew.

Needless to say, Mr. Taylor was upset and so was I. Eventually, Mr. Taylor decided to pay out-of-pocket for the evaluation in Greenwood and fortunately, this biopsy came out negative.

But this was a situation that Mr. Taylor should never have had to face. No patient should. But unfortunately, situations like this one happen far too often.

Everyone here has had patients like Mr. Taylor. Patients whom you care for, and whom you want to care for, but the system makes it almost impossible to do so.

Instead needless, inappropriate and arbitrary barriers are placed between us and our patients — not only damaging our relationships with them, but also our credibility as physicians.

This kind of problem must stop — and they must stop now.

I believe forming an insurance company to support MPCN can help us put an end to this craziness. Because this initiative will help put medical decision-making back where it truly belongs — in the hands of physicians and the patients we care for — medical colleagues who understand the importance of maintaining our patient-physician relationships — and the values and principles these relationships encompass.

In simplest terms: Physicians who understand that you don't send a patient off to Memphis when he's getting competent and compassionate care right there in his own backyard. That is why I am committed to this effort and why I am making it a priority.

What's more — I'm optimistic that we can get the job done. A survey conducted last year indicated that some 85 percent of this membership supported this idea in concept.

The challenge, however, is turning this support into action. Working with the Montgomery-Smith Vaniz firm, the Board has put together a plan for raising the needed funds. This plan is described in detail in the prospectus which you all have received. And during the next few months, other board members and I will be traveling the state, sharing the specifics of this plan with you.

We are planning to make some 30 to 40 visits across the state to get the word out and to build support for this program. And I encourage you to attend at least one of these meetings and to bring a colleague.

Because to be successful in this endeavor — we will need the support of physicians from outside this room as well. And that will be my other priority as President: To reach out to our colleagues who are not part of MSMA — and urge their participation and support. Not just for this initiative, but for all the good work that MSMA is doing.

Whether its working for legislative change in Jackson...improving physician practice...or addressing local health needs in our communities. We need all Mississippi physicians working together to be successful.

As leaders, I'm asking for your help in making that happen. Tell your colleagues about the important work we're doing, how it impacts them, how it improves patient care and why they need to be involved.

The fact that you're here shows that you understand the importance of our work and the benefits that come from working together. All I am asking is that you share this message with others. Because as I said, we need all Mississippi physicians working together to be successful.

In closing, a friend of mine asked me recently, he said, "Mike, What do you hope to accomplish as president, anyway?" And I told him the same priorities that I shared with you today. My hopes for taking MPCN to the next level and creating a physician-owned and operated insurance company. And my desire to get more of our colleagues involved in this and other MSMA efforts.

But my ultimate goal as president can be stated even more simply than that. Because my ultimate goal is this: To leave MSMA, a very important organization that we all care about deeply and work so hard to support, just a little better and a little stronger this time next year.

With your help and support this will happen. I thank you so much for the honor to serve as your president and I look forward to working with each and every one of you during the year ahead.

Thank you.

-Michael H. Carter, Jr., M.D.



Michael H. Carter, Jr., M.D.

The President's Page

Ensuring Fair E & M Guidelines

There are some things that one just can't do alone; successfully challenging the Health Care Finance Administration (HCFA) over ridiculous regulations is one of them. However, like many problem situations which physicians encounter these days, when we unite and work together for the common good, we can make a positive difference.

In late April the AMA hosted a fly-in meeting for state and specialty society leaders to discuss physician concerns about the revised documentation guidelines for evaluation and management services recently issued by HCFA. This meeting was a collective effort put together by the only physician organization that could pull it off — the AMA — and resulted in a prompt and appropriate response from HCFA to the physicians' objections.

In direct response to physician concerns, supported by vigorous and coordinated advocacy efforts by the AMA, state medical associations and medical specialty societies, HCFA Administrator Nancy-Ann Min DeParle promptly announced that the offensive guidelines would not be implemented. In a letter to AMA President Percy Wootton, M.D. the administrator promised the following:

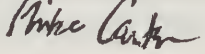
1. An indefinite delay in implementation, with review in Fall 1998, allowing sufficient time to make needed changes to the guidelines.

2. HCFA will study a new set of revised guidelines, currently under development, and then conduct a pilot test.

3. HCFA also is instructing Medicare carriers to limit fraud referrals to cases of intentional actions to defraud, not cases of inadvertent error.

4. HCFA has made a commitment to educate physicians and carrier review personnel thoroughly, prior to implementation of the eventual E & M documentation guidelines.

All of us recognize that documentation is necessary. But, required documentation must have utility and pertinence, yet not be overly burdensome. As your advocates, MSMA and the AMA will continue to work through organized medicine to the end of ensuring that the eventual E & M guidelines are minimally intrusive, are fair to physicians, and do not hinder our ability to practice good medicine.



Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXIX, NUMBER 7
JULY 1998

Boomers, Busters and Organized Medicine

Indulge me for a moment. Envision the Mississippi State Medical Association as a coalition. We are an "Association of Associations," a unified alliance of very distinct subgroups.

The very nature of a coalition implies the forging together of entities that are used to being independent bodies and uniting them with a common goal. MSMA is not simply comprised of eight geographic districts. Look at the amazing diversity of our group. Within the fold we have specialty groups such as the OB-GYN Association, who treat patients from the womb... to our Pathologists' Association studying what takes us to the tomb, and all the rest of the specialties in between. Each of these groups holds its own meeting down at State Medical in Biloxi each year. We have a gender specific subgroup now as well, "Women in Medicine." Although our numbers are still slim, I recall a time a few years ago when the Women in Medicine group could have held a caucus in a broom closet.

Then there are generational subsets. There was a breakfast for the "50-Year Club" on one hand, and the "Young Physician's Section" (physicians under 40) elsewhere.

This never really hit home to me until at this year's annual meeting. While running for the District 2 Board position, I actually tried to make all the caucus meetings to at least "show my smiling face." Whew, talk about running around like a schizophrenic chicken with its head cut off!

"Let's see, which group am I with now? What hat do I wear here?" It was great fun though.

There are also physician groups whose numbers have not yet become organized such as minority physicians, osteopathic physicians, and foreign medical graduates.

But, hey, I'm not totally convinced we should be so fragmented anyway. Where do you draw the line? Do we need a "Society for the Disillusioned and Disenfranchised Rural Physicians of Mississippi'? And what about the growing group "Part-Time Doctors who are Amway Distributors?"

I know . . . what about a group called "The Pseudo-Physicians of the Magnolia State"? This would be the largest caucus of all I expect. I guess I carried that one too far . . . back to reality.

A strong coalition of physician groups is necessary because society (in general) and Medicine (in particular) have become increasingly complex. There is a continuous daily explosion of issues: technological, fiscal and ethical. What individual person or specialty society can keep pace with this? This is why MSMA is so important to Mississippi Physicians.

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

What are the characteristics of a great coalition?

1. Willing allies who share your position.
2. Members who "Bring something to the party"... raw numbers, good public image, political clout, geographic distribution, diversity, and funding.
3. Strong leadership.
4. Effective internal communications.
5. Effective external (media) communications.
6. Sound political judgement.
7. Mutual trust.

When you look at national statistics sometimes you get the feeling that the term "organized medicine" is an oxymoron. Just how organized are physicians anyway?

Thirty years ago in the halcyon days of organized medicine, 75 percent of all physicians were active members of the AMA. Today that figure hovers around 35%. In our state the percentage is 67 percent which is one of the highest in the nation.

I believe that associations are at risk. The viability of organized medicine is at risk. Much of this has to do with the generational differences at play here. Being careful not to stereotype, we have within our ranks the "traditionalist physicians," or the "G.I. generation" if you will, folks currently 52 and above. This group has always been "joiners" and have been the backbone of the AMA for many years. Next come the "baby boomer docs," now aged 34 - 51, a very individualistic group. And now we have the "new generation - generation X" (also known as Busters), those physicians currently 33 and under. We don't have a good handle on them yet.

Now you put these groups together around a meeting table and you will hear something like this....

The Fearless Leader says, "we need to proceed with 'project A' because it is urgent and important." A traditionalist at the table would say, "I agree, I make a motion we vote to start 'project A' right away."

The "baby boomer" will probably then ask "Why?," not necessarily dissenting, but always questioning everything.

The "gen-x-er" is sitting there asking, maybe not aloud, "What's in it for me? Is this going to be worth my time? Will this be fun?"

Now, none of these thought processes are inherently right or wrong. But different generations have distinct modes of thought. We as an association have to understand what people are looking to receive from MSMA, from organized medicine in general.

Thirty years ago doctors looked to their medical association for two things: CME and social activities. Now, the "busters (the x-men)" get their CME off the computer and have figured out how to play at work.

Now young physicians seem only to want their medical association to help them make more money and stay out of jail.

The point of it all is that the MSMA and the AMA must be uniquely responsive to the needs of every generation we serve. We can no longer afford to see ourselves as "ten feet tall and bulletproof." We must rethink our position constantly and change strategy periodically to make it more compelling for people to participate. If young physicians are convinced that we're not wasting their time, and if they believe that what we're doing is important, they will respond.

One way we can ensure continued interest in MSMA is by maintaining a strong legislative plan. It also answers the perennial membership question: "What have you done for me lately?" Association members want to know what you have achieved recently, what you are currently working on and what's ahead. The agenda we have not yet completed... the opportunities and obstacles we still have in front of us... show why we are worthy of future involvement, a time commitment and a check for membership dues.

We MSMA members all need to grow in our understanding of the political process and its value to the survival of our profession. We as an association need to be careful with issues that don't generate consensus. We cannot let divisive issues draw our physician coalition apart. Nothing will kill a legislative program faster than conflicting voices from our side of the battlefield.

Somebody must run this great ship called "Medicine." Someone must take the lead. Keeping everyone moving and together is a serious and daunting challenge. I think we're up to it.

Ultimately as an organization we will always be a viable force for good if we never forget our "home base" - our patients. If we do this, MSMA will not only survive, it will thrive in the next millennium.**-Dwalia S. South, M.D.**

Mrs. H. Allen Gersh Installed New MSMA Alliance President



The MSMA Alliance held their 75th Annual Session in conjunction with MSMA's 130th Annual Session, May 14 - 17, 1998. During the Alliance House of Delegates meeting, Friday, May 15, 1998, Mrs. H. Allen (Cathy) Gersh was installed 1998-99 MSMA Alliance President. Shown above: *Cathy Gersh, Hattiesburg, and Mrs. George (Jane) Ladner, Jackson.*



The MSMA Allaince Past-President's Breakfast was held Saturday, May 16, 1998. Shown back, left to right: *Merrell Rogers, Jean Hill, Jo Waites, Cathy Gersh, Jane Ladner, Kathy Carmichael and Nancy Lindstrom.* Shown front, left to right: *Peggy Crawford, Sylvia Walker, Martha Tatum, Nancy Bush and Roberta Barnett.*



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Dear Dr. Lockey:

I read with interest the article in the April 1998 issue of the Journal of the Mississippi State Medical Association, "Laryngeal Nerve Monitoring During Thyroidectomy" by Dr. C. Ron Cannon. Injury to the recurrent laryngeal nerves with vocal cord paresis or paralysis is perhaps the most feared complication of thyroidectomy. The question of whether the nerve should routinely be identified or dissection should be maintained close to the thyroid gland to avoid the nerve is a source of ongoing debate between many experienced thyroid surgeons. The availability of devices to attempt to monitor proximity of dissection to recurrent laryngeal nerves and avoid injury to nonrecurrent nerves and anatomic anomalies in the nerves such as proximal decussation of the nerve into multiple thin branches is puzzling. Such devices are no substitute for thorough knowledge of thyroid, parathyroid and recurrent nerve anatomy and a healthy respect for the potential presence of anatomic anomalies such as nonrecurrence. They serve to provide inexperienced surgeons with a false sense of security and in reality provide no margin of safety. They are, at best, a gimmick. An experienced thyroid surgeon should be able to perform thyroidectomy with an incidence of recurrent nerve injury of well less than 1%. Certainly, all of us who have done a significant volume of thyroid surgery have seen recurrent nerves who have transient hypofunction after being subjected to dissection, but if the nerve is anatomically intact, nerve function should return. Intraoperative monitoring devices of all types are subject to errors of positioning, data acquisition and data monitoring. None of them can stand in for clinical judgment and a thorough working knowledge of the anatomy being operated upon.

Thank you for your time and consideration.

With kindest regards, I remain sincerely yours,

Phillip B. Ley , M.D., Surgical Oncology

Dear Dr. Lockey:

Each day during the Legislative session I come in contact with Charmain Thompson, our MSMA Director of Legislative Affairs. I feel that our membership should know that Charmain represents us in a very professional manner and is a credit to our organization. First of all she is very intelligent and is respected by other legislative contact persons as well as the Legislators.

Charmain needs the help of all of our members when an alert is called. Don't forget ... the members of the Legislature listen closely to their physicians back home!

Sincerely, **Rep. Jim C. Barnett, M.D.**

Department of Defense
Office of the Commander

Dear Doctor:

The Jackson Military Entrance Processing Station (MEPS), located in Jackson, Mississippi, is responsible for conducting physical exams on applicants for the United States Armed Forces. At the present time the Station has a need for several Fee Basis Physicians to help conduct these physicals.

The Jackson MEPS is located in a modem building with excellent working areas. Experienced military and civilian health technicians are present to facilitate the medical and laboratory work for each applicant. Working hours vary from four to six hours per day, depending on the number of applicants with the average pay being $225.00 per day. The applicants receive no medical treatment, nor is any treatment allowed. Only diagnostic skills are required by the Fee Basis Physicians.

There is no age restriction for the physician; but, each physician must be legally licensed to practice medicine in Mississippi. The Fee Basis Physicians presently working here are all retirees. If you are interested in part time work, please contact the station at 355-4747 (Medical) or 355-3645 (Headquarters) for more information.

Sincerely,

T.S. Lever
Major, U.S. Army
Commanding Officer

W.E. "Mike" Caldwell
Chief Medical Officer

Dear Editors:

Why not bypass for-profit, third-party HMOs and empower district officers of the State Health Department to expand Mississippi's county health clinics where primary health care for everyone is offered. Many clinics are staffed by capable people with many years of primary health care experience. They are established and do not need "services" of paper-pushing HMOs. District health officers like Dr. Alfio Rausa in Greenwood and Dr. Robert Travnicek in Gulfport are much more competent to make humanitarian health care decisions than, say, insurance company executives. They are positioned to budget the money state lawmakers allocate, without CEOs of health service businesses carving out a chunk.

Corporate boards make too many patient care decisions, which medical professionals should make. More and more medical personnel become slaves to decisions favoring stockholders. Subrosa tiers of avarice multiple in a far-flung medical services industry. Many seeking health

care get services to become victims of expensive, overvalued, diagnostic and treatment procedures. No patient escapes wiles of big business to dominate profits creamed where fear of disease and death haunt the people. Instead of health care reform a hydra-headed conglomerate has been created.

But help may be on the way. Dedicated physicians like Dr. Koop, universities, medical schools, and other social institutions are beginning to understand that a new health care paradigm for humanity, instead of for business, has begun. A multitude of young men and women once again are answering the call to dedicate their lives to caring for the poor, sick, and sufferers around the world.

If Mississippi lawmakers can be inspired to sign on as public health clinic advocates, primary medical care can be expanded in all county health clinics of The Magnolia State.

John Alford, semi-retired M.D.

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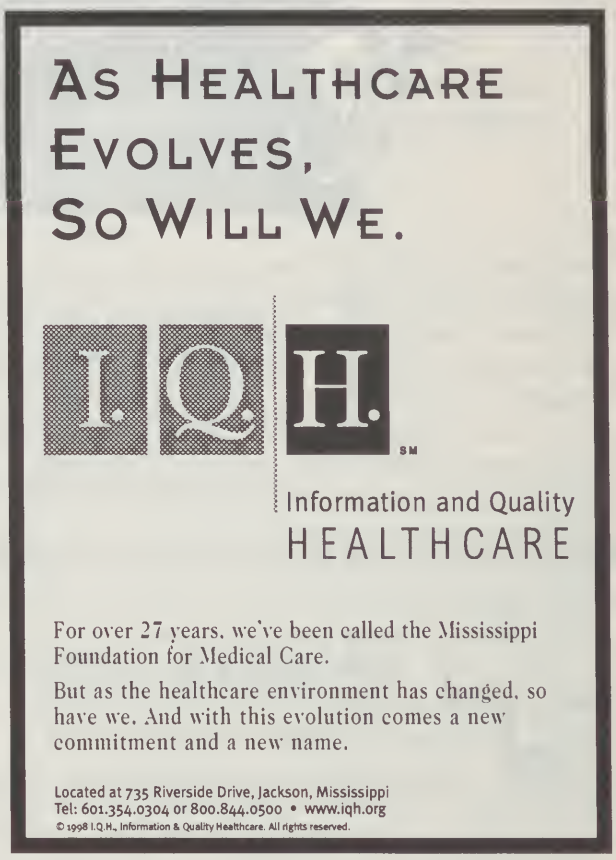
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Physicians Care Insurance Company (PCIC) on the Move

MSMA House of Delegates, in November1997, approved plans to capitalize a health insurance company. A stock prospectus was mailed to all MSMA members in April and meetings are currently being conducted throughout the state to present plans for the health insurance company Physicians Care Insurance Company (PCIC). Drs. Fred L. McMillan and James C. Waites presented a 10 minute video on the PCIC purpose and development during the 130th MSMA Annual Session. There was also a separate presentation to the MSMA Alliance. Both presentations were well received with numerous positive comments.

"All too often, during these periods of change, people suffer from a sense of negativity about the uncertainties of the future. Those who sit back and only complain and express dissatisfaction will have little influence on the new directions of medical care, while those who take responsibility for effecting the changes they believe will be best for their patients and themselves will clearly be the ones to have a major voice. The development of a plan that is owned and controlled by physicians themselves is a positive opportunity to demonstrate in the marketplace that physicians can organize the delivery of high quality medical care that is also cost-effective," said Dr. McMillan, president of the PCIC Advisory Board. "It is an opportunity to return to true 'managed care' - care that is managed by the physician and patient working together in the patient's best interest. We are asking you to work with us to erase the negativity that seems to overwhelm many of our colleagues. This project can and will succeed, but only with the involvement of physicians. Because the managed care market is beginning to expand in Mississippi, this will probably be the best opportunity for a physician-controlled entity to be successful in our state. We cannot afford to miss this opportunity," he said.

For more information on PCIC contact Jackye Wiebelt, 1-800-898-0251, (601)354-5433.



MSMA Executive Director Charles L. Mathews Retires After 30 Years - William F. Roberts Named New Director



Charles L. Mathews gives that classic "Charlie" look as his colleagues roast him.



Phoebe and Charles Mathews with MSMA Executive Assistant Alicia Thames.

The annual president's dinner for the Board of Trustees held before annual session broke tradition for the occasion of MSMA Executive Director Charles L. Mathews' retirement roast. Past-presidents and other state executive directors close to Mr. Mathews surprised him with their presence and offered testimonials in his honor before the opening of the 130th Annual Session in Biloxi, May 14-17, 1998.

The year marked Mr. Mathews' 35th year of attending MSMA's annual session and his 26th year of delivering the executive director's annual report to the House of Delegates. On Sunday, May 17, William F. Roberts became MSMA's new executive director.

Following the retirement party, Mr. Mathews was presented with a new Chevrolet Tahoe, which he said will be "perfect for trailering [his] cabin cruiser" and enjoying his retirement.

Mathews first served nine years as MSMA's assistant executive director, then left the association to serve as staff assistant to Gov. John Bell Williams. After holding the positions of deputy director of the Mississippi



MSMA's new Executive Director, William F. Roberts, and his wife, Marilyn.

Medicaid Commission and then Mississippi's Commissioner of Welfare, he accepted the position of MSMA executive director in 1972.

MSMA President, Michael H. Carter Jr., M.D. noted, "Charlie has dedicated a three-decade career to the advancement of organized medicine. He has guided the association through the quagmires of Medicaid and managed care, and he has helped us build a sturdy House of Delegates. When he returned to MSMA, Carter said, he brought an insight into government programs that for the past 26 years has been of great benefit to MSMA and our members."

"I arrived to find our membership pushing efforts to ensure that the legislature adequately funded the state's first four-year medical school," Mathews said, "which our members played such a large part in establishing. Subsequently, their concerns and efforts have resulted in the association implementing a wide range of projects impacting the practice of medicine."

They have included in chronological order of implementation such projects as:

• Serving as fiscal intermediary in Mississippi for the Dependents Medical Care Program for the Uniformed Services (now CHAMPUS).

• Serving as a contractor for the Experimental Medical Care Review Organization (EMCRO) project funded by Congress to demonstrate a physician directed peer review program.

• Forming the Mississippi Foundation for Medical Care (MFMC) and subsequently implementing the Professional Standards Review Organization (PRSO) in Mississippi.

• Forming the Mississippi Medical Fraternal and Educational Society (now MACM) to provide professional liability insurance to members of the association.

• Establishing the MSMA Benefit Plan & Trust to provide and administer a health benefits program for physicians, their employees and families under ERISA.

• Forming the Mississippi Physicians Insurance Company, Inc. to provide a HMO to Mississippi employers/employees and later reorganizing the company to provide worker's compensation insurance for physicians offices and other selected employer groups.

• Forming the Mississippi Physicians Care Network (MPCN), a statewide physician sponsored preferred provider network (PPO).

• Forming the Physicians Care Insurance Company (PCIC). (Currently being organized and one of several state and county medical society sponsored health insurance carriers.)

Former Associate Executive Director and Legal Counsel William "Bill" Roberts has taken over Mathews' role as executive director. Mr. Roberts served as Washington counsel for the AMA Washington office and as director of field staff of AMA. "Bill and I met through the Medicaid program back in 1970," Mathews said, "and he has the experience needed to fill this position."

"Through Charlie's leadership, the MSMA has prospered as much or more than any state medical association I know," commented R. Faser Triplett, M.D., MSMA past president and current president and chairman of the board of Medical Assurance Company of Mississippi. "He has constantly brought to the members' attention the need to meet the challenges that medicine faces head-on. I will always remember him for the loyalty he exhibited to the medical profession, to the Mississippi State Medical Association, and particularly to each of us as individual members."

Dr. Carter added, "Most of us know Charlie from the myriad of AMA projects to which he contributed or from his impact on Southern Medical Association programs. Any attempted list of his contributions would be an understatement. He is so much more."



Elvis (Senator Tim Johnson) surprised Charles with a serenade.

Actions of the House of Delegates 130th Annual Session

MSMA conducted its 130th Annual Session of the House of Delegates at the Biloxi Grand Hotel on May 14-17, 1998. The meeting attracted a total of 407 registrants, including 198 physicians, 20 guests, 5 medical students and residents, 68 members of the MSMA Alliance and 107 exhibitors.

The educational program for this year's meeting was entitled "Medical Practice in Mississippi: Current Issues in Preventive Health, Ethics and Government". Among the numerous operational and public policy actions taken by the House of Delegates during its two sessions were the following:

• Approved a future Annual Session schedule format which reduces the meeting from three and one-half to two and one-half days;

• Received reports on the increased growth of Mississippi Physicians Care Network, the status of the stock offering to capitalize the Physicians Care Insurance Company, and plans for the construction of a new MSMA headquarters building;

• Granted honorary MSMA membership to Charlie Mathews on the occasion of his retirement as the association's Executive Director after 26 years, and commemorated the accomplishments of Dr. Sidney Graves by adopting a memorial resolution to be placed the board room of the new MSMA headquarters facility;

• Adopted a resolution urging the Mississippi Medical Political Action Committee to develop a plan to recruit more physician candidates for the Mississippi Legislature;

• Adopted a resolution asking the AMA to work with public and private third party payers to develop a standard "Explanation of Benefits" form that would be used by all payers;

• Adopted a resolution urging the Mississippi Congressional Delegation to oppose the expansion of Medicare to early retirees;

• Adopted a resolution calling for the State of Mississippi to develop a comprehensive policy to deal with the conversion of non-profit hospitals and health insurance companies to profit entities;

• Adopted a resolution reaffirming the association's opposition to expanded practice by non-physician practitioners and urged the MSMA Board of Trustees to expand its efforts to protect the practice of medicine from scope of practice infringements by non-physician practitioners;

• Adopted a resolution urging the Mississippi Insurance Department to enforce state laws requiring payment of "clean" health insurance claims within 45 days;

• Adopted a resolution directing the MSMA General Counsel to provide members with current legal guidelines on providing "professional courtesy;"

• Adopted a resolution opposing the federal government's requirements for using documentation guidelines for Evaluation and Management CPT codes;

• Adopted a resolution stating that MSMA does not consider it unethical for a physician to exercise the right to "opt out" of Medicare and bill privately for their services pursuant to the Balanced Budget Act of 1997;

• Referred a resolution to the Board of Trustees dealing with including a mandatory "point of service" option in health plans that restrict choice of physician and an "any willing provider" requirement.

Newly Elected Officers, Board & Council Members

Serving as MSMA Board members and officers during the 1998-99 association year will be: Chester Masterson, MD, Vicksburg, Chairman; T. Steve Parvin, MD, Starkville; Vice Chairman; John J. Cook, MD, Jackson, Secretary; Hugh A. Gamble, II, MD, Greenville; Dwalia South, MD, Ripley; Nancy O. Tatum, MD, Jackson; Charles L. Wilkinson, MD, Meridian; Ben M. Carmichael, MD, Hattiesburg; Hal Moore, MD, Pascagoula; President; Michael H. Carter, Jr., MD, Greenwood, President; W. Briggs Hopson; President-elect; H. Vann Craig, MD, Natchez, Immediate Past President; and Helen R. Turner, Jackson, Secretary-Treasurer. Mrs. H. Allen (Cathy) Gersh, President of the MSMA Alliance will serve as the Alliance representative to the Board.

President-Elect ..... W. Briggs Hopson, MD, Vicksburg
Alternate Delegate to the AMA..... Michael H. Carter, MD, Greenwood
Alternate Delegate to the AMA ..... H. Vann Craig, MD, Natchez
Alternate Delegate to the AMA..... Nancy O. Tatum, MD, Jackson
Delegate to the AMA .....Candace E. Keller, MD, Hattiesburg
Delegate to the AMA..... George E. McGee, MD, Hattiesburg
Delegate to the AMA..... Mal G. Morgan, MD, Natchez
Editor, Journal MSMA..... Leslie E. England, MD, Natchez
Associate Editor, Journal MSMA..... D. Stanley Hartness, MD, Kosciusko
Associate Editor, Journal MSMA..... Lucius M. Lampton, MD, Magnolia
Board of Trustees, District 2..... Dwalia S. South, MD, Ripley
Board of Trustees, District 4..... Nancy O. Tatum, MD, Jackson
Board of Trustees, District 5..... Charles L. Wilkinson, MD, Meridian
Council on Budget and Finance..... John M. Estess, MD, Hollandale
Council on Constitution and By-Laws..... Mary Gayle Armstrong, MD, Madison
Judicial Council, District 1..... Kenneth L. Hines, MD, Greenwood
Judicial Council, District 3 ..... Henry L. Edmonson, MD, Starkville
Council on Legislation, District 1..... Al Rausa, MD, Greenwood
Council on Legislation, District 2..... William A. Middleton, MD, Winona
Council on Legislation, District 3..... Thomas E. Sheffield, MD, Columbus
Council on Medical Education, District 4..... Roland B. Robertson, MD, Jackson
Council on Medical Education, District 5.....William A. Billups, III, MD, Meridian
Council on Medical Service, District 4 ..... Frank W. Bowen, MD, Carthage
Council on Medical Service, District 5..... J. Glenn Peters, MD, Louisville
Council on Public Information, District 1..... William B. Jones, MD, Greenwood
Council on Public Information, District 2..... Tim J. Alford, MD, Kosciusko
Council on Public Information, District 3..... John M. Patterson, MD, Pontotoc
Chairman, Hospital Medical Staff Section..... Rodney E. Frothingham, MD, Greenville



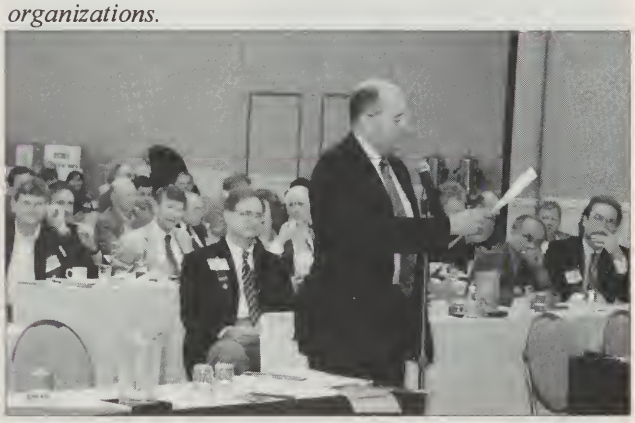
W. Briggs Hopson, M.D. of Vicksburg was elected MSMA President-Elect. Dr. Hopson is a general and peripheral vascular surgeon with The Street Clinic in Vicksburg, chief of staff of ParkView Regional Medical Center, medical director of the clinics and a member of the board of directors of River Region Medical Corporation. He is a member of the Governor's Commission on Health Care and is chairman of the Trauma Care Task Force. Dr. Hopson and his wife, the former Patricia Spearman of Oxford, Mississippi, have four children.



Speaker of the House Dr. George E. McGee of Hattiesburg helped make the meetings of the House of Delegates productive, interesting and efficient. Upon Speaker McGee's recommendation last year, the MSMA bylaws were amended to permit use of Davis' Rules of Order as the official parliamentary guide for the conduct of business by the House of Delegates. The parliamentary guide was developed by Dr. James Davis, a former AMA President and Speaker of the AMA House of Delegates. The ***Davis Rules of Order*** *are now being utilized by the AMA and many other medical organizations.*



Drs. Mal Morgan, (left to right) *Leslie E. England and Stanley Hartness mark their ballots. Dr. Morgan was re-elected AMA Delegate. Dr. England was elected Editor and Dr. Hartness Associate Editor of the JOURNAL MSMA.*



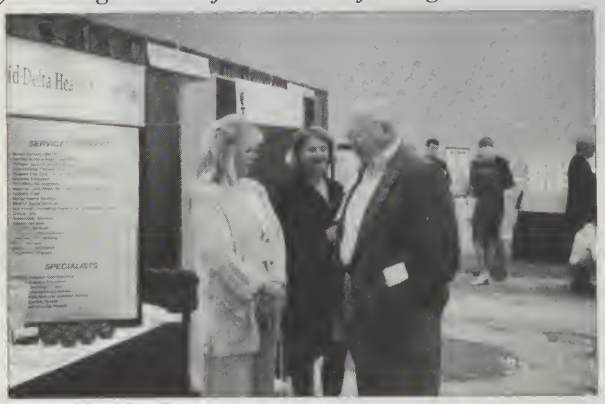
Dr. Al Rausa, Greenwood, was among those introducing reports and resolutions at the initial meeting of the House of Delegates for consideration by Reference Committees.



1997-98 MSMA President H. Vann Craig, M.D. presented the 1998 Community Service Award to William C. Gates, M.D. during the Thursday morning session of the House of Delegates.



Candace E. Keller, M.D. presented the American Medical Political Action Committee (AMPAC) award to the Mississippi Medical Political Action Committee (MMPAC) in recognition of its 1997 membership recruitment activities. Accepting the award on behalf of MMPAC was W. Briggs Hopson, M.D.



Ellis M. Moffitt, M.D. visits one of the many exhibits.



Council on Public Information Member Alfio Rausa, M.D. presented the Award for Media Excellence in Medical Reporting in the broadcast category to Bill Day and his wife, WMDN-Meridian, for an informative 30-minute program titled "Diabetes-Learning to Live."



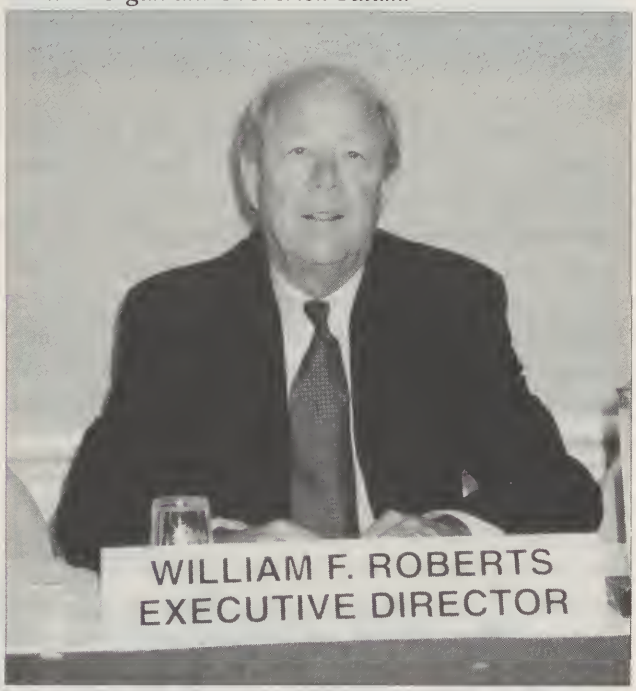
Ellen Wright Clayton, M.D., J.D., Associate Professor of Pediatrics, Associate Professor of Law, at Vanderbilt University was the James Grant Thompson Memorial Lecturer for the Saturday plenary sesssion. Her presentation, "What You Should Be Telling Families About Genetic Testing," was well received.



In a pre-session Board meeting U.S. Attorney Brad Piggott defended his pursuit of physicians, hospitals and other health care providers who he says are filing false claims for Medicare reimbursement. Piggott presented his position regarding the False Claims Act. Piggott did, however, request additional information from the Board on ways to distinguish between intentional fraud and simple billing errors and invited the association to send a representative to meetings of his fraud task force.



The Fifty-Year Club held a breakfast on Saturday, May 16, 1998. In attendance were Drs. John Alford, Claude Austin, Gerald Gable, Martin Hancock, Ralph Brock, Frank Vogel, Frank Morgan and Frederick Tatum.



William F. "Bill" Roberts is MSMA's new executive director.



The meeting attracted a total of 407 registrants, including 198 physicians, 20 guests, five medical students and residents, 68 members of the MSMA Alliance and 107 exhibitors.

Information and Quality Healthcare

The 1998 Annual Session for the membership marked the first meeting under the new name, I.Q.H., Information and Quality Healthcare. Held in conjunction with the State Medical Association convention, the meeting featured the announcement of newly elected members of the board of directors, recognition of retiring board members, a presentation on the physician office audit program, and special awards.

Elected to serve on the board were Drs. John Patterson, who is a family practitioner in Pontotoc; Rodney Frothingham, neurosurgeon from Greenville; Sam Pace, internal medicine, Tupelo; Tom Jeffcoat, orthopedic surgeon, McComb; Glenn Peters, family practice, Louisville, Leonard Brandon, family practice, Starkville; Charles Brock, family practice, Cleveland; John Cook, emergency medicine, Brandon; Leslie England, internal medicine, Natchez; and Kenneth Reid, pediatrician, Meridian. Their terms expire in the year 2000.

Terms expiring in 1999 include those of Drs. George Abraham of Vicksburg, Mary Gayle Armstrong of Madison, Robert DeCoux of Hattiesburg, Jack Evans of Laurel, Thomas Fenter of Jackson, Joe Files of Jackson, John Hassell of Laurel, Braxter Irby of Brookhaven, David Irwin of Tupelo and Eugene Webb of Greenwood. Dr. Abraham, Dr. Armstrong, Dr. Evans, Dr. Hassell, and Dr. Webb are family practitioners. Dr. DeCoux's specialty is gastroenterology/internal medicine; Dr. Fenter, urology; Dr. Files, internal medicine/hematology; Dr. Irby, internal medicine; Dr. Irwin, cardiovascular disease.

Retiring board members recognized at the session were Dr. Hugh Gamble of Greenville, Dr. David Hall of Natchez, Dr. Karl Hatten of Clarksdale, Dr. Joseph Hillman of Columbus and Dr. John Paul Lee of Forest. Consumer representative J. L. Scott of Jackson was recognized, as was Wayne Harris of Mendenhall, Simpson General Hospital administrator.

Bylaws limit service to two consecutive two-year terms.

Hospital administrators now serving on the board include John Dawson of North Mississippi Medical Center in Tupelo and Bill Oliver of Forrest General Hospital in Hattiesburg.

Dr. Leonard Brandon, who has served as board chairman for the past year, opened the session, and pointed out the change in the PRO name. Dr. James McIlwain, I.Q.H. president, recognized retiring executive director Fred Parish, who spoke about his 23 years with the Foundation.

Dr. McIlwain announced that Dr. Jack Evans of Laurel was the A. A. Derrick Award recipient for his contributions to and support of quality medicine. A native of Newton, Dr. Evans has been with the Laurel Family Practice Clinic since 1983. He studied at the University of Mississippi, the University of Mississippi Medical Center, and completed his internship in family practice at the University of Tennessee in Memphis. He completed his residency in family practice at University Medical Center.

A diplomate in the American Board of Family Practice, he also serves as a clinical instructor with the UMC Department of Family Medicine. He has served as president of the South Mississippi Medical Society, chairman of the Department of Medicine at South Center Medical Center, and chief of staff at South Central. In addition to his terms of service on the I.Q.H. board, he has also served on the board of the Mississippi Academy of Family Physicians. He and his wife Betty have three children, Eric, Laurie and Emily.

The award is given in honor of Dr. Derrick, who served the peer review/quality improvement organization as board member, chairman and quality medicine supporter. Dr. Derrick died in 1993.

Dr. Alton Cobb, clinical coordinator for I.Q.H., recognized two clinics for outstanding participation in a quality improvement project, the Jackson Medical Clinic and the Grenfell, Evans and Dyess Clinic for the outpatient diabetic management project. Dr. Earl Fyke Jr. accepted the award for the Jackson Medical Clinic. Dr. Cobb also

recongized hospitals who received special quality awards at the May 1 Quality Showcase sponsored by I.Q.H. The Spirit of Continuous Quality Improvement Award went to Baptist Memorial Hospital-Golden Triangle in Columbus. An Award of Excellence recognizing the hospital showing exceptional achievement in several quality improvement projects went to Memorial Hospital at Gulfport. Special recognition awards honored hospitals exhibiting exceptional achievement in a single continuous quality improvement project; they were Delta Regional Medical Center, Greenville, for its Cooperative Cardiovascular Project, and North Mississippi Medical Center in Tupelo, Atrial Fibrillation Project. South Panola Hospital, Batesville, was recognized with an Award of Merit for its accomplishment in continuous quality improvement projects.

Dr. David Hall, who has served as board treasurer, spoke on the importance of the physician office audit program.



Dr. Jack Evans



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Representation, advocacy, public relations and support of professional ethics are some of the reasons MSMA exists for its members. These are the intangible but important benefits of membership which MSMA seeks to provide through member participation. There are also more tangible benefits which the association provides its members. Illustrated here are the MSMA-sponsored programs for such member needs as insurance and practice management support. These programs are listed below.

MEMBERSHIP HOTLINE
The MSMA provides a toll free WATS for any member to call to inquire about medical matters and programs of the association. Inquiries about AMA programs and policies can also be made over a membership WATS line.

MEDICAL OFFICE SUPPLIES
MSMA members can save up to 40 percent on medical office supplies through "AMA Purchase Link". Under this program discounted medical, surgical and pharmaceutical products are available from Henry Schein, Inc., the largest nationwide distributor of such products to physicians' offices.

THIRD PARTY PAYOR LIAISON
MSMA conducts liaison with Travelers Medicare, Medicaid and other third party payor programs on behalf of its members. Individual claim problems, as well as general policy matters, are important aspects of this liaison. For further information call Jackye Wiebelt at MSMA.

HEALTH INSURANCE
MSMA members who are organized as PAs and wish to provide health insurance coverage for their employees are eligible to participate in a self-insured 501(c)(9) trust sponsored and administered by a subsidiary of the association. For information contact Jackye Wiebelt at MSMA.

WORKERS' COMPENSATION INSURANCE
The MS Physicians Insurance Company (MPIC) is affiliated with MSMA and currently provides workers' compensation coverage to physicians' offices at the lowest rates available. MS law requires every employer with five or more employees to obtain such insurance. For further information contact Gusta Stanford at MPIC.

PRACTICE MANAGEMENT
Through an arrangement with the AMA Department of Practice Management, MSMA periodically conducts practice management workshops for physician's office personnel. These workshops cover a broad range of topics from CPT-IV coding to patient surveys. For further information call Jackye Wiebelt at MSMA Diversified Services, Inc.

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AUGUST 1998

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About the cover:
This photograph of sunrise at Horn Island, Mississippi was taken in May 1977 by Virginia Moffitt Crawford, M.D. There was terrible weather during the night as her family camped on the island; however, they awoke to a beautiful sunset. Dr. Crawford is an internist with interests in preventive health service, adolescent medicine and women's health who practices Student Health Services at the University of Southern Mississippi. Married to E. Howell Crawford, M.D. they have three sons and live in Hattiesburg.

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Suicide in Mississippi- A Growing Concern

Susan Hart-Hester, Ph.D.
Patrick O. Smith, Ph.D.

Abstract

Every time the clock ticks down 42 seconds, someone in this country attempts suicide with success occurring every 17 minutes. Every hour and 39 minutes, the suicide victim is below the age of 15.[1] Overall, suicide is the ninth leading cause of all United States (U.S.) deaths. For young persons aged 15-24, suicide is the 3rd leading cause of death and a growing problem among youngsters ages 5 through 14.[2] Suicides in children less than 15 years of age has nearly tripled over the last forty years.[3] Statistics show that among industrialized nations, the U.S. has the highest rates of childhood homicide, suicide, and firearm-related deaths.[3] Therefore, the purpose of this article is fourfold: 1) to provide Mississippi's suicide statistics, 2) review suicide risk factors, 3) elucidate prevention and intervention strategies, and 4) relay available resources. Concerns for the development and implementation of needed prevention programs are also discussed.

Rate of Suicide in Mississippi

Suicide is a complex violent behavior, crossing all ages and social barriers which causes methodological problems for accurate scientific inquiry. Classification of many suicides as "accidental deaths" decreases incidence and prevalence reliability. Additionally, frequent co-morbid conditions such as substance abuse and psychiatric disorders confound suicide reporting.

In 1994, Mississippi's suicide rate ranked thirtieth in the United States. Figures from the American Association of Suicidology (AAS) showed a higher suicide rate among Mississippi whites (14%) compared to the U.S. (12%). For Mississippi African-Americans, the suicide death rate was the same as the national rate (7%). *Descriptive statistics, Mississippi Vital Statistics (1984-1995), compiled by the Mississippi Department of Health are summarized in Tables 1 through 5 and show a breakdown of Mississippi suicides by race, sex, and age (5). Table 1 shows total number of suicides by year and a breakdown by race. Data shows the number of caucasians committing suicide in Mississippi is 4 to 5 times the number of non-caucasians.*

Table 1
Number of Suicides by Race

Year	Total Suicides	Total Suicides by Caucasians	Total Suicides by Non-Caucasians
1984	273	227	46
1985	271	221	50
1986	292	246	46
1987	282	244	38
1988	297	245	52
1989	316	257	59
1990	289	243	46
1991	325	263	62
1992	331	268	63
1993	327	261	66
1994	313	247	66
1995	318	258	60

Source: Mississippi Vital Statistics Manuals, 1984-1995

Table 2
Number of White Male Suicides from 1984 to 1995

Year	Total by Sex & race	Age Groups								
		1 - 4	5 - 9	10-14	15-24	25-34	35-44	45-54	55-64	65 +
1984	177	0	0	1	27	27	26	26	23	47
1985	176	0	0	2	30	25	23	24	23	49
1986	185	0	0	0	33	27	23	27	26	49
1987	189	0	0	0	21	35	30	29	19	54
1988	190	0	0	1	29	26	21	28	24	61
1989	190	0	0	3	30	25	32	25	16	57
1990	198	0	0	2	27	38	37	22	25	47
1991	202	0	0	0	29	33	32	26	31	51
1992	211	0	0	0	41	44	37	19	27	43
1993	214	0	0	2	37	40	35	30	22	48
1994	205	0	0	1	32	46	35	24	17	50
1995	210	0	1	4	38	35	34	26	23	49

Source: Mississippi Vital Statistics Manuals, 1984-1995

Table 2 depicts a relatively stable suicide rate across all age groups with a larger number of aged white males committing suicide from 1984 to 1995. Graph 1 demonstrates the fluctuation of suicides among 15-24 year-olds.

Graph 1: White Male Suicides in 15-24 Year Olds

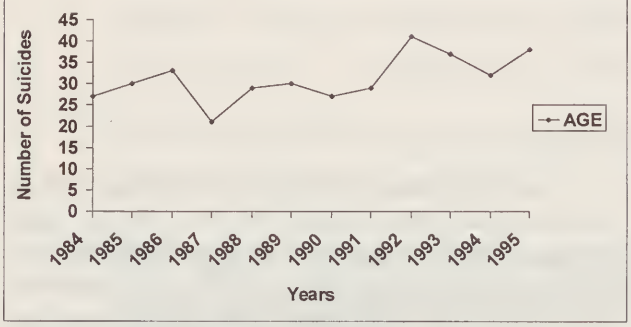


Table 3 reaffirms national statistics indicating a lower number of suicides for females. However, graph 2 shows fluctuations in the number of completed suicides for the 25 to 34 age group, particularly from 1987 to 1990 and from 1993 to 1995.

Graph 2: White Female Suicides in 25-34 Year Olds

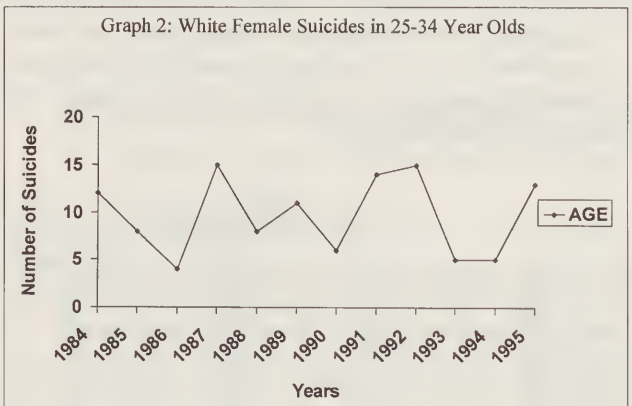


Table 4 indicates an increasing trend in the number of suicides for African-American males ages 15 to 34. Graph 3 depicts the fluctuation of numbers from year to year; however, these numbers remain higher than any of the other age groups across years.

Table 3
White Female Suicides from 1984 to 1995

Year	Total by Sex & race	Age Groups								
		1 - 4	5 - 9	10-14	15-24	25-34	35-44	45-54	55-64	65 +
1984	50	0	0	1	6	12	7	8	14	2
1985	45	0	0	0	8	8	8	5	8	8
1986	61	0	0	1	7	4	13	11	13	12
1987	55	0	0	1	4	15	11	8	7	9
1988	55	0	0	0	8	8	9	4	15	11
1989	67	0	0	2	6	11	14	9	13	12
1990	45	0	0	1	9	6	7	6	6	10
1991	61	0	0	1	4	14	14	6	7	14
1992	57	0	0	1	3	15	18	6	5	9
1993	47	0	0	0	6	5	9	7	9	11
1994	42	0	0	0	6	5	9	7	8	7
1995	48	0	0	0	5	13	5	10	7	8

Source: Mississippi Vital Statistics Manuals, 1984-1995

Table 4
Non-White Male Suicides From 1984 to 1995

Year	Total by Sex & Race	Age Groups								
		1-4	5 - 9	10 -14	15-24	25-34	35-44	45-54	55-64	65 +
1984	37	0	0	0	13	12	2	1	4	5
1985	41	0	0	0	11	13	7	5	2	3
1986	34	0	0	1	13	5	3	3	2	7
1987	35	0	0	2	7	10	3	3	2	8
1988	42	0	0	0	8	16	3	5	4	6
1989	49	0	0	2	11	19	5	3	2	6
1990	38	0	0	0	11	8	5	5	5	4
1991	52	0	0	0	13	18	11	5	0	5
1992	49	0	0	1	12	20	6	2	4	4
1993	58	0	0	2	21	14	7	4	3	7
1994	55	0	0	1	22	18	7	4	1	2
1995	52	0	0	1	17	14	9	3	3	5

Source: Mississippi Vital Statistics Manuals, 1984-1995

Graph 3: Non-White Male Suicides in 15-34 Year Olds

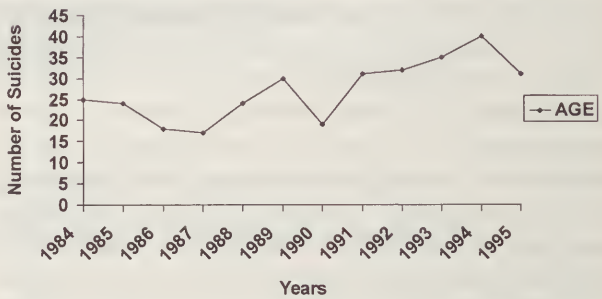


Table 5 shows a lower number of African-American females choosing suicide than their white counterparts. With the exception of female African-Americans over 65, the number per age group is minimal.

Table 5
Non-White Female Suicides From 1984 to 1995

Year	Total by Sex & Race	Age Groups								
		1-4	5 - 9	10 -14	15-24	25-34	35-44	45-54	55-64	65 +
1984	9	0	0	1	0	3	1	2	1	1
1985	9	0	0	0	3	0	1	3	0	2
1986	12	0	0	1	1	4	1	1	1	3
1987	3	0	0	0	3	0	0	0	0	0
1988	10	0	0	0	3	2	2	0	2	1
1989	10	0	0	1	2	2	3	0	0	2
1990	8	0	0	0	2	0	2	1	1	2
1991	10	0	0	0	1	4	1	1	1	2
1992	14	0	0	0	4	3	3	1	3	0
1993	8	0	0	0	3	3	0	0	1	1
1994	11	0	0	0	4	1	3	0	1	2
1995	8	0	0	0	1	1	0	1	1	4

Source: Mississippi Vital Statistics Manuals, 1984-1995

For Mississippians, firearms are the most common suicide method accounting for 254 of the 318 suicide deaths during 1995.[4] While firearms were the most frequent choice, hanging and poisoning ranked second and third, with 27 and 26 deaths respectively. Although females attempt suicide more often than males (3:1), four times more males than females successfully complete suicide. Highlighting these statistics by grade level and race, females from all races and at each grade level (9th -12th) report a greater percentage suicide consideration during the past twelve months when compared to males. Again, more females than males indicated that they had actually made a suicide plan during the past 12 months. Although more females than males had actually attempted suicide one or more times during the past 12 months, more males required medical attention after attempting suicide. This statistic was particularly true for males in the 11th grade. Moreover, the suicide rate of Mississippi young persons ages 15-24 in 1994 was higher (15.3) than the national rates from 1990 through 1994; (13.2 to 13.8). In six years Mississippi has seen a 57 percent increase in teen suicides.[5] To prevent this trend's continuation, acknowledgment of suicide consequences and risk factors is the first step in a state-wide action plan.

Estimates of Suicide Sequela

Although no official U.S. data are compiled on the effect suicide has on family, friends, and relative "survivors", it is estimated that each suicide influences a minimum of six other people.[1] Thus, U.S. suicides left 186,000 survivors yearly with at least 1,908 Mississippians or an average of 23 people per county experiencing grief and loss due to suicide by an acquaintance. These persons will experience a sequela that includes shock, anger, grief, and loss. Many will evaluate the victim's behavior prior to suicide and consider their role in prediction and possible prevention.

Can we predict suicide?

Although we cannot accurately predict suicide, suicide contemplators demonstrate common behavior patterns that may be used for suicide prevention.[6] However, many of these behaviors are comorbid with other disorders making detection of potential suicidal behavior difficult. Table 6 is a comprehensive review of warning signs.

Risk factors interact and may be used to identify high risk populations. One example includes minority incarcerated juveniles in Mississippi. The rate of suicides for African-Americans in the U.S. has increased by 165% from 1980 to 1992, and the result is a number of minorities incarcerated in Mississippi's correctional institutions are committing suicide.[3] Data from Table 4 show that African-American males ages 15 to 34 are completing suicide at a higher rate than corresponding age groups. According to the National Institute of Mental Health (1997), incarceration places an individual at risk for successful suicide. During 1996, twenty-seven counties in Mississippi committed juveniles to correctional institutions at a rate higher than the state average of 4.7.[5] Identifying high risk populations and being vigilant in underlying warning signs for suicidal behavior is an important step in the process of prevention and treatment.

Table 6
Warning Signs or "Risk Factors"

Discussing suicide	Clinical Depression	Giving away possessions	Reading, Drawing, Writing about death
Saying Good-bye as if making final arrangements	Loss of interest in friends, hobbies, occupation	Isolation; Living Alone	Abuse of alcohol or drugs
Sleep disturbances	Appetite fluctuations	Crying episodes	Tardiness or absence from school/work
Hopelessness	Irritability; moodiness; anger	Older white male	Suicide ideation
Anxiety	Mental Disorder	Stressful Life Events	Increase in physical illnesses
Familial Suicide	Cognitive Rigidity	Behavior changes: sexual promiscuity, destructiveness, illegal activities	Self-criticism; Low self esteem
Religious Ideas	Economic Problems	Marital problems	Occupational Problems

List compiled from multiple sources: (7,8,9, 10 & 11)

Prevention of Suicidal Behavior

Recognizing predictors of suicidal behavior necessitates the reciprocal identification of instrumental behaviors for family, friends, and professionals to utilize with those who attempt suicidal behavior. The following set of intervention recommendations provides a *"BALANCED" Approach* for the recognition and interruption treatment of suicidal behavior:

Believe the warning signs: Don't attempt to provide explanations for the individual's behavior that delay your attempts to intervene. Don't try to do everything yourself. Seek help from colleagues, other professionals, or the victim's family members.

Accessible: Be accessible to the person.

Listen: Listen carefully and talk directly about suicide. Ask the individual if he or she is thinking about suicide and inquire about their plans. "Have you thought about killing yourself?" "Have you developed a plan for suicide?" If so, "How do you intend to kill yourself?" Discuss consequences with the person. "What will happen as a consequence of killing yourself?" Often pa-

tients will think of their family and friends reaction and this can be a strong deterrent to action.

Action Plan: Help the individual develop an action plan for assistance. Identify steps that the person can take when intrusive suicidal thoughts occur-these thoughts are recurrent, non-stoppable, and uninterruptable. Have them repeat the steps of the plan to insure follow through when distressed.

Non-judgmental: Be non-judgmental by sharing unconditional positive regard. Don't try to argue with the individual. Remind him or her that their depression can be treated; that there are other alternatives. Talking about their feelings is an important step.

Consistent involvement: Show continued support for the individual's treatment. *Monitor* their compliance with prescribed medications and therapy sessions. Find out about the side effects of the medications. Remain available to talk and listen.

Extract: *firearms, drugs, medications, obvious instruments* that the individual could use to harm themselves. Obviously, you can't remove every thing. Think along a *continuum of expediency*-what does the person like to do? Is he/she a hunter? Are there firearms in the home?

Dial 911: Decide to take immediate action if warning signs are present, a plan has been developed, means are available, and the suicidal thoughts are intrusive. Do not leave the person alone to wait for a resource to "open." *Dial 911 and ask the dispatcher for assistance.*[7,8]

Available Resources

While a personal commitment to help the individual is an important factor in preventing suicide, recognizing appropriate resources for professional assistance is vital. Twelve to 20 percent of the youth in the U.S. have some form of mental health problem; however only 1 to 5 percent actually receive services due to poverty.[12] Available resources for Mississippians of all ages are frequently couched within existing frameworks such as the community mental health centers network. Access in rural service areas is often limited by suicide stigma. First contact with suicidal individuals is often made by a single family member, friend, or family physician. Professional management of the suicidal person may include some combination of hospitalization, pharmacotherapy, and psychotherapy. Access to group therapy settings will vary according to the location of the hospitals and mental health services. Physicians serving in rural counties without a hospital will find limited options for dealing with the suicidal individual. Metropolitan crisis hot lines offer limited scope for the rural patient in need of immediate contact and follow-up. Physicians need to establish mechanisms for referral of suicidal clients. Implementation of current legislative measures such as those outlined in Senate Bill 2100 will establish equitable services for citizens across all regions of Mississippi, albeit rural or urban.

Recommendations

Physicians and healthcare professionals need to work as members of the prevention team before and after suicidal behaviors are recognized. With the increasing number of school age children committing suicide, it is important for professionals to be actively involved in prevention programs. School related services for Mississippi's youth are typically addressed through the counselors office, if they are addressed at all. Although Mississippi's school accreditation standards require high school counselors, it is unclear how many districts provide trained counselors for elementary and junior high students. Programs addressing suicide facts and warning signs are needed at all age levels, but particularly so at the junior high and high school grades. Youngsters need to know that suicidal thoughts need not lead to actual attempts. Teaching coping skills and communication are vital ingredients for the school age curriculum. Additional training is needed for school personnel (i.e., teachers, coaches, cafeteria workers, etc.) in the recognition of early warning signs, referral procedures and resources, as well as school intervention policies. Physicians and health professionals can play a pivotal role in the dissemination of such information to parents, children, and educators. These strategies can facilitate greater assistance to an adolescent population at high risk for suicide.

Additionally, preventive strategies should be implemented with Mississippi's elderly population. Data show the increasing number of elderly Mississippians committing suicide. Therefore, greater attention should be paid to the mental health care of our elderly citizens. There exists a great need for the establishment of adult and peer support groups. These groups need to be established for suicide survivors (attempted suicide), as well as individuals who have survived the death of a parent, spouse, family member, or friend to suicide. Currently, one adult survivor support group functions within the state under a church's sponsorship. Additional support groups are needed throughout the state. Under the guidance of knowl-

edgeable, trained professionals, these support groups provide a necessary model for establishing coping skills as well as networking between survivors and professionals.

Support teams need to be trained to visit on-site following a suicide. Professional Emergency Personnel (via; police, firefighters, and paramedics) need to be trained in responding to family and friends of a suicide victim. Family members of suicide victims can ultimately work together on crisis teams with professionals. Such tactics can prevent other suicides and assist grieving family members in locating professional services.

Conclusion

Mississippi's growing number of suicides is an alarming statistic. Recognition of at-risk behaviors and preventive measures can help reduce the number of successful suicides. Additional study is needed regarding the incidence of suicide among young African-American males and older white males in Mississippi. Preventive strategies for school-age youth should be incorporated into every elementary and secondary school curriculum within the state in an effort to decrease the number of children who become victims of suicide.

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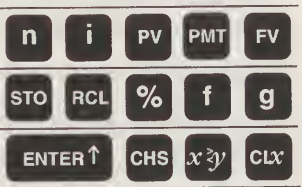
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Coding Concepts

Q. Is there any rule of thumb or printed guidelines to alert the coder to bundling edits?

A. CPT conventions offer a few clues to bundling edits. For instance codes designated as separate procedures should be used with caution. These codes may be part of another major procedure provided that day. Only bill a separate procedure designated code for the following circumstances:

1) When the separate procedure is the only service or procedure provided that day.

2) When the designated separate procedure is not related to the family of the major procedure.

Since Medicare is often the pace setter in defining policy, you may want to obtain and review a copy of their bundling edits. Medicare has approximately 73,000 bundling edits effective as of January 1996. A copy of these bundling edits may be obtained from NTIS - a Washington, D.C. based company who has contracted with HCFA to supply the edits. Medicare published the phone numbers and order numbers in the winter issue. You cannot obtain a copy of the new "coding Initials" from your Medicare carrier due to a copyright agreement with

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Administar Federal, the company who created the new edits. However, Medicare can supply you with costing and ordering information. The three ways to obtain the new edit are as follows. 1) Paper copy 2) On diskette 3) By section.

Q. Our practice has been contracted to provide sport physicals for several local high schools. Which code(s) would you suggest we use to track these services? Also, what would be an appropriate diagnosis code?

A. Code selections to report or track sports physicals would be based on the actual service provided by the physician. If the physician documents a comprehensive history and physical, you would use a code from Preventive Medicine Services (99381 - 99397) based on the age of the student. If, however, the physician only documented a brief, detailed, or extended history and examination, you would select a code from the Evaluation and Management section (99201 - 99215.) With both code series, you will need to establish if the student is a new patient or an established patient.

To report the medical necessity or justification for the service, refer to the V codes in ICD-9-CM. V codes are used when the patient presents for reason other than illness or injury, to report factors that influence patient health, or for statical information. The correct ICD-9-CM code would be V70.3, *Other administrative services*.

CODING TIP

Before selecting a code, be sure that the documentation supports the level of service billed and that information for the diagnosis is complete. List any conditions or factors that affect the patient's care or conditions being treated for that visit.

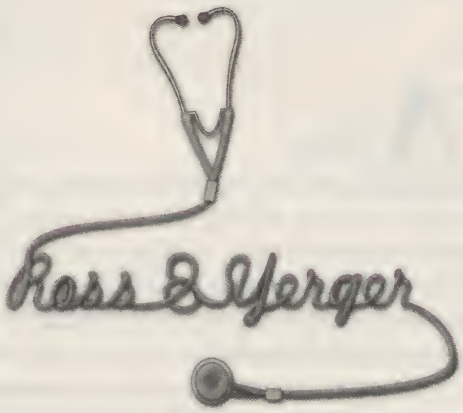
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Wanda L. Adams, CPC, Healthcare Consultant and published author. Founder and past president of the St. Louis Chapter of the AAPC. She currently serves on the National Advisory Board of the AAPC and the Editorial Panel of Code Facts, a Medicode publication.

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Screening Colorectal Cancer- Rational Guidelines

Walter T. Boone, M.D.

Abstract

Colorectal cancer is the third most commonly diagnosed cancer and the second leading cause of cancer deaths in The United States. It affects men and women equally and increases with the age of the population. The adenoma-adenocarcinoma sequence presents a unique opportunity for interdiction in the progression to colorectal cancer. Our screening and surveillance recommendations are cost effective and reduce the incidence and mortality of colorectal cancer. Most of our progress in the last decade has come from the screening and surveillance of high risk categories of patients for colorectal cancer. If progress is to continue, we must carry our message to the general population with average risk factors wich constitutes 75% of colorectal cancer.

Colorectal cancer

In 1997, it was estimated that 150,000 new cases would be diagnosed and about 60,000 patients would die of this disease. In Mississippi, colorectal cancer deaths numbered 6,000 in 1997.[1] Physicians and other health care personnel who treat patients with metastatic and fatal colorectal cancer have been seeking ways to advance early detection and, as a consequence, ensure improved survival, reduce mortality and a better quality of life.

It is generally accepted that most cancers of the colon and rectum develop from adenomatous polyps. (Figure 1) The progression from normal mucosa to an adenomatous polyp to cancer appears to be associated with an accumulation of genetic alterations that are acquired after birth, resulting in genes that promote the development of cancer as well as loss of genes that suppress tumor development.

It is rare for an adenomatous polyp to progress to cancer.[2] In those polyps that do, the transformation from small adenomas to cancer seems to occur slowly over many years. The average time taken for this transformation ("polyp dwell time") is not precisely known. However, based on several lines of evidence, it is estimated that it takes an average of about ten years for an adenomatous polyp, particularly one less than 1.0 cm. in diameter, to transform into invasive cancer. Because of these time sequences, colorectal cancer lends itself to a successful screening and surveillance program.

Most Americans are not currently screened for colorectal cancer. Personal household surveys and telephone surveys of 38,000 people over age 50 found that at least 60% of the population had neither fecal occult blood tests or sigmoidoscopy during the preceding five years.[4,5] In recent years, the incidence and mortality of rates of colorectal cancer have decreased, after having consistently increased over the past few decades. Figure II shows the age adjusted incidence and mortality of colorectal cancer for both male and female of all races between 1973 and 1992. These trends could be explained by removal of premalignant polyps, earlier

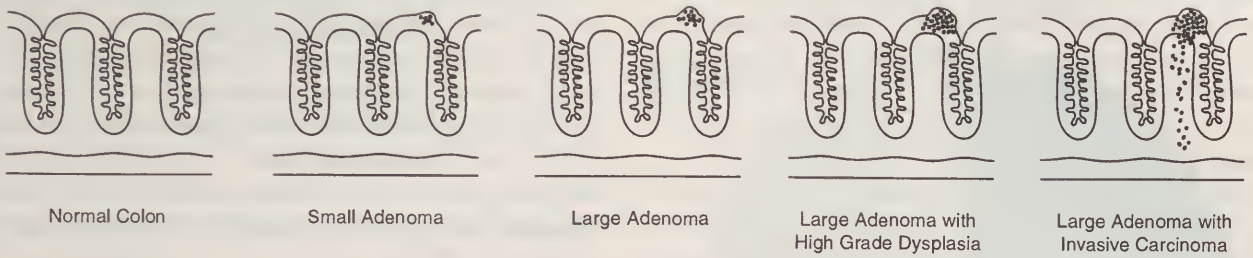


Figure 1. Adapted from: O'Brien MJ, Winawer SJ, Waye JB: Colorectal polyps. In: Winawer SJ ed. Management of gastrointestinal diseases. New York: Gower Medical, 1992.

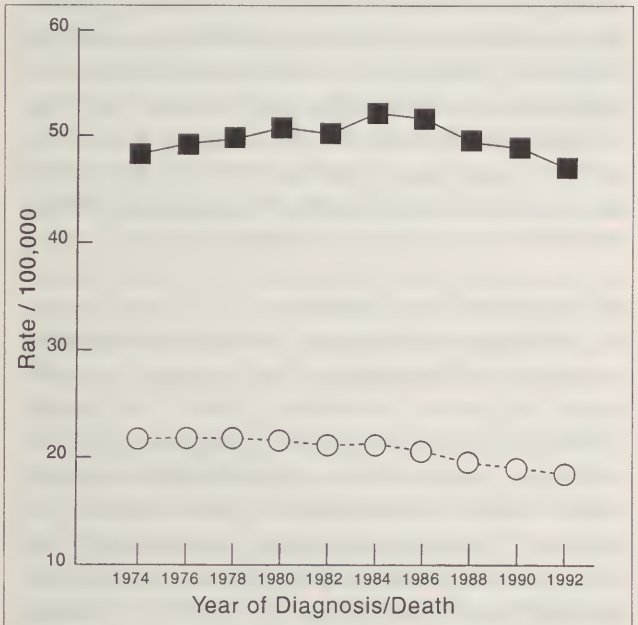


Figure 2. Age adjusted incidence (■) and mortality (○) of CRC in the general population over time; SEER program (total, male and female, all races, colon and rectum, 1973-1992). Surveillance, Epidemiology, and End Results (SEER) Program, 1973-1992. Winawer, SJ et al. Gastro 1997; 112: 544-642.

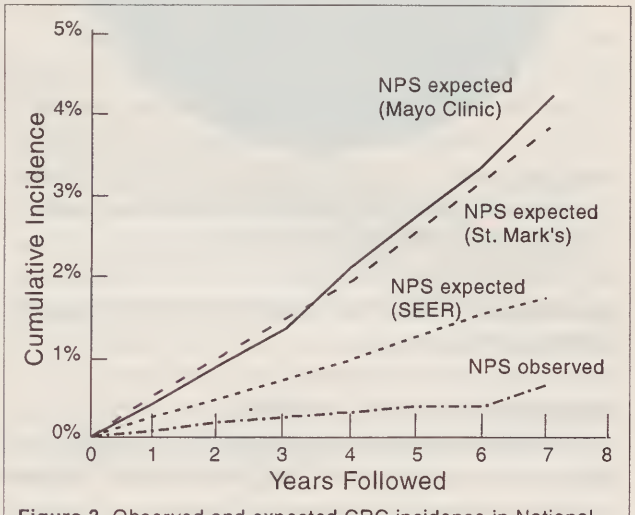


Figure 3. Observed and expected CRC incidence in National Polyp Study cohort after colonoscopic polypectomy. Winawer SJ, N Engl J Med 1993: 1977-1981.

detection, more accurate diagnosis, lower incidence, or more effective treatment; it is uncertain in what proportions each of these contribute. That colonoscopy and polypectomy make a significant contribution to the reduction in the incidence and mortality of colorectal cancer is suggested by the national polyp study with a cohort of 1,418 patients. (Figure III) These patients in the national polyp study underwent complete colonoscopy and removal of one or more adenomatous polyps from the colon or rectum. They were followed for an average of 5.9 years per patient with periodic colonoscopy. After adjusting for age, sex, and polyp size, rates of colorectal cancer were 76% to 90% lower than expected from comparison with three reference groups who had not undergone surveillance colonoscopy.

About 75% of all new cases of colorectal cancer occur in people with no known predisposing factors for the disease.[6] (Figure IV) These are the patients who would benefit most from a concerted community emphasis on screening for colorectal cancer.

Family history is immensely important in colorectal cancer. With health care as news making articles, patients have become more attuned to the importance of family history in their medical records. People with one or more first degree relatives, parent, sibling, or child with colorectal cancer, have approximately twice the risk of developing colorectal cancer as average risk individuals without a family history. In those with a single affected first degree relative, the risk significantly increases in the fourth decade and continues to increase with age.[7] The risk seems to be further increased if more than one first degree relative has colorectal cancer and if the relative's cancer occurred relatively early in life (before 55 years of age).[8] There are two specific genetic

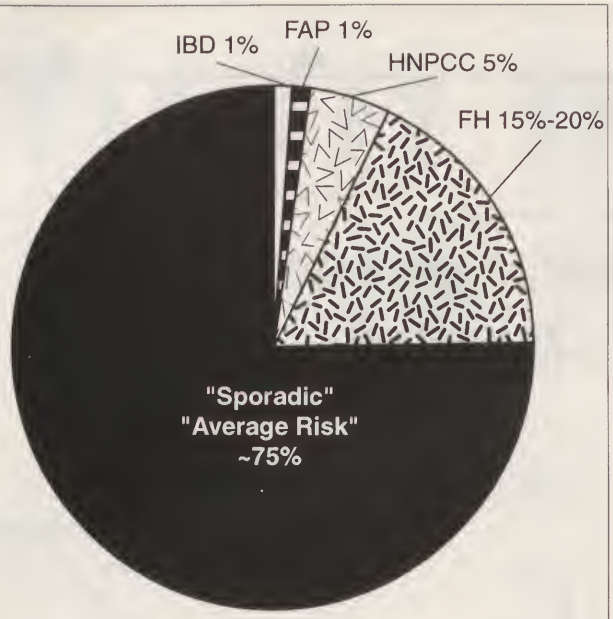


Figure 4. Factors associated with annual new cases of CRC. Sporadic, men and women age 50 and older with no special risk factors; FH, positive family history.
Winawer SJ, et al. J Natl Cancer Inst 1991; 83:243-253.

HNPCC - Amsterdam Criteria
Colorectal Cancer
in
- **3** relatives (1 first degree)
- **2** generations with colorectal CA
- **1** less than age 50

Figure 5. HNPCC - Lynch Syndrome. Dis Colon Rectum 1991; (34) 5:424-25.

syndromes in which the majority of affected persons develop colorectal cancer.

Familial adenomatous polyposis.

FAP accounts for approximately 1% of the new cases of colorectal cancer in The United States.[9] Affected individuals develop adenomatous polyps in the second and third decades of life and usually have hundreds to thousands of polyps throughout the colon by their thirties. There is almost 100% chance of developing colorectal cancer by their forties. There are variations of this syndrome which include Turcot's Syndrome (familial colorectal and brain cancer) and Gardener's Syndrome (familial colorectal cancer, osteomas, and benign soft tissue tumors).

Hereditary nonpolyposis colon cancer.

HNPCC, also known as the Lynch Syndrome, accounts for about 5% of new cases of colorectal cancer each year. The syndrome is defined by The Amsterdam Criteria (Figure 5). These criteria are strict and consist of the existence of three or more relatives with documented colorectal cancer, one of whom is a first degree relative of the other two; colorectal cancer involving at least two generations; and one or more cases of colorectal cancer diagnosed before age 50 in the family.[10] The clinical syndrome has two main forms: one without a family history of other cancers (Lynch Syndrome I) and the other with an increased familial occurrence of other types of cancers, typically of the ovary and uterus (Lynch Syndrome II). In both variations of the syndrome, patients develop adenomatous polyps with higher frequency at a younger age than people without HNPCC. The polyps have more advanced pathology and often are multiple. In addition, there seems to be a more rapid transformation of adenomas to cancer in this syndrome compared with the general population even with respect to small adenomas. Colorectal cancers occur at an early age in the fourth and fifth decades, and the cancers are predominantly proximal to the splenic flexure.[11]

Inflammatory Bowel Disease

Although inflammatory bowel disease patients make up a small proportion of new cases of colorectal cancer, they are at substantially greater risk than the general population. The risks associated with Ulcerative Colitis and Crohn's Colitis are similar for comparable extent, duration, and age of onset of inflammatory bowel disease.[12] The two strongest predisposing factors for development of cancer in IBD patients are the anatomical extent of the inflammation and the duration of disease. Most cancers do not occur until after eight years of pancolitis.[13]

Prior colorectal cancer.

In a St. Marks Hospital study, 4,119 patients were followed for up to forty years. Risk was low (1.9%) in the first ten years and then increased to about four times the risk of the average population. The risk of developing a new colorectal cancer is calculated to be 0.35% per year after curative intent resection.[3]

(Surveillance Methods)

Our screening and surveillance tools for detection of colorectal cancer include fecal occult blood tests, flexible sigmoidoscopy, colonoscopy and air contrast barium enema or combinations.

Fecal occult blood tests.

A growing body of evidence has established that

testing for fecal occult blood with a followup complete diagnostic evaluation of the colon reduces mortality from colorectal cancer. Rehydration increases the proportions found by screening but also increases the proportion of patients who have a false positive test and must undergo diagnostic testing.[14] Three randomized trials[14,15,16] of fecal occult blood testing have shown a 15%, 18%, and 33% reduction in colorectal cancer mortality in the screened group.

Sigmoidoscopy

The flexible sigmoidoscope (60.0 cm.) has largely replaced the rigid one because the actual depth of insertion is higher, the optics are better, and the comfort of the patient is greater; thus patient compliance is improved.

If an adenomatous polyp is found on sigmoidoscopy there is an increased possibility that others are present in the bowel.[17] Several studies have compared the performance of the 60.0 cm. flexible sigmoidoscopy with that of full colonoscopy in the same group of asymptomatic patients.[18,19] Of interest, the 60.0 cm. flexible sigmoidoscope correctly identified 40-60% of all adenomas detected by colonoscopy. Additionally, the characteristics of the proximal adenoma (size) correlates well with the characteristics of the rectosigmoid adenoma.

There are three studies demonstrating the effectiveness of sigmoidoscopy in reducing deaths from colorectal cancer (59%, 80%, 60% reduction).[20,21,22] Most all of this data was achieved by rigid sigmoidoscope, and the reduction in mortality reflects the part of the colon reached by the rigid sigmoidoscope. By inference, the 60.0 cm. flexible sigmoidoscope should be more effective than the rigid instrument.[23]

Fecal occult blood testing plus flexible sigmoidoscopy.

There are multiple theoretical reasons why the combination of sigmoidoscopy and fecal occult blood testing should amplify the detection of colorectal cancer. In one large study including 12,500 people with a five to eleven year followup, the mortality from colorectal cancer was lower in the combination and associated with earlier stage detection and longer survival.[24]

Barium Enema

Double contrast barium enema has become regarded as the best x-ray for detecting small mucosal lesions and cancer despite more patient protest and expense. Results of the clearest studies[25,26] suggest a sensitivity of 50-80% for polyps less than 1.0 cm., 70-90% for polyps greater than 1.0 cm., and 55-85% for Duke's stage A and B cancers. False positive findings are very high for small polyps. Most studies suggest that performance of a double contrast barium enema, although lower than colonoscopy, is sufficient to detect the majority of clinically important lesions.

There are no control comparisons of effectiveness of barium enema in screening for colorectal cancer in which death or any other adverse health outcome was measured. However, as any other screening test, the detection of polyps and early cancers reduces the incidence and mortality from colorectal cancer, and the air contrast barium enema detects many of these lesions.

Flexible Sigmoidoscopy Plus Barium Enema

The combination of flexible sigmoidoscopy plus double contrast barium enema has been used because often overlying loops in the rectosigmoid are difficult to separate with a double contrast barium enema. Radiology often complains that a flexible sigmoidoscope leaves too much air in the colon for a proper barium enema to follow. A randomized trial of double contrast barium enema plus flexible sigmoidoscopy vs. colonoscopy in 383 patients found that colonoscopy detected more cases of polyps less than 9.0 mm. than did double contrast barium enema plus sigmoidoscopy. However, there was no difference between the two groups in the number of patients detected with cancers or polyps greater than 9.0 mm.[27,28]

Colonoscopy

Colonoscopy has assumed the gold standard for screening and surveillance of colorectal carcinoma because of it's ability to diagnose, biopsy and or remove lesions from anywhere in the entire colon. Colonoscopy is less accurate when the polyps are very small. A retrospective review of 429 patients who had colorectal cancers and polyps resected after undergoing preoperative colonoscopy found that the findings at colonoscopy correlated with the pathological specimen in 97% of cases, but the colonoscope missed the lesion in 3% of the cases.[29] A colonoscopist would counter that this study is almost a decade old and does not take account of the improvement in optics, preparation, and instrumentation. However, colonoscopy does have it's blind spots even when performed in tandem by two examiners.[30]

As with barium enema, there are no published studies that define the effectiveness of colonoscopy as a screening test for colorectal cancer. There is striking and indirect evidence that detecting and removing polyps reduces the incidence of colorectal cancer, (Figure 3), that detecting early cancers lowers the mortality from the

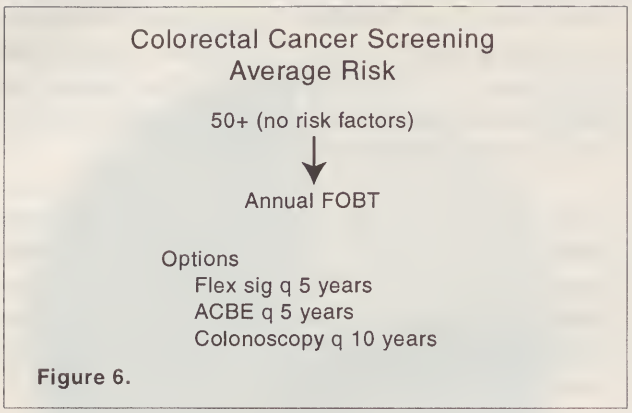


Figure 6.

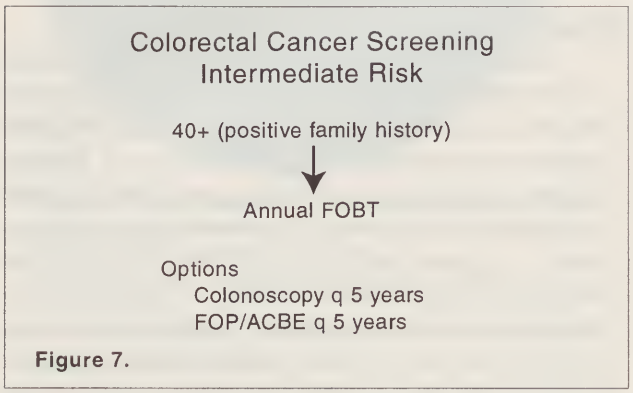


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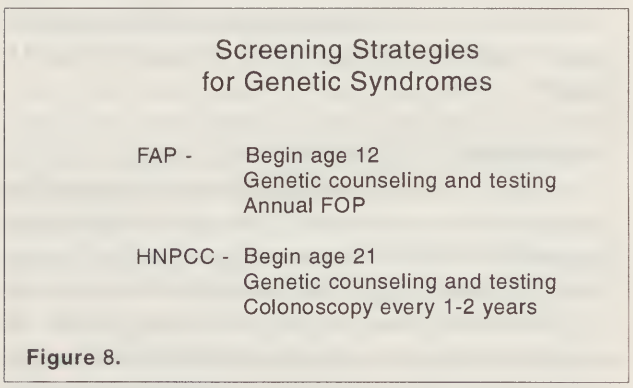


Figure 8.

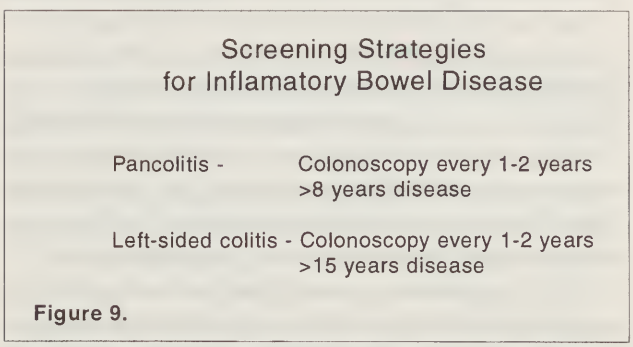


Figure 9.

disease, and that colonoscopy detects most of these lesions.

Screening Strategies for Average Risk

For an asymptomatic age 50 patient with no other risk factors, several options are available. (Figure 6) Stools for occult blood must be checked at yearly intervals. Most patients and physicians select colonoscopy followed, in preference, by flex sig/air contrast barium enema for their initial screening. Third party payment denials may make colonoscopy less available. Importantly, any positive finding mandates a complete evaluation of the entire colon.

Screening Strategies for Patients with Intermediate Risk (Family History - Colorectal Cancer / Adenomatous Polyp)

Patients with a first degree relative (sibling, parent or child) who has had colorectal cancer or an adenomatous polyp should begin screening at 40 years old as their incidence of colorectal cancer is comparable to that in patients at normal risk at age 50. (Figure 7)

They should have stools checked for occult blood yearly. Colonoscopy or fiberoptic procto/double contrast barium enema should be offered at five year intervals. Special efforts should be made to assure that screening of these patients take place.

Screening Strategies for Genetic Syndromes

Familial adenomatous polyposis

Unaffected parents of patients with familial adenomatous polyposis are usually aware of the significant history of colon cancer or colostomy in their pedigree. These young patients should receive genetic counseling and genetic testing to detect gene carriers (Figure 8). Flexible sigmoidoscopy should be accomplished annually beginning at age twelve to determine if there is gene expression. Colonoscopy is usually not helpful in detecting advanced pathology because there are so many polyps. After the syndrome is confirmed, colectomy is the treatment of choice and should be accomplished as soon as acceptable to the patient.

Hereditary non-polyposis colorectal cancer

These patients are more difficult to recognize than is a family history of familial adenomatous polyposis. Screening should begin by age twenty one. Genetic counseling and testing should be offered. Colonoscopy should be accomplished every one to two years as there is evidence that progression of small adenomas in their transformation to cancer is accelerated in HNPCC compared with the sporadic adenoma - adenocarcinoma sequence.[31]

Screening Strategies for Inflammatory Bowel

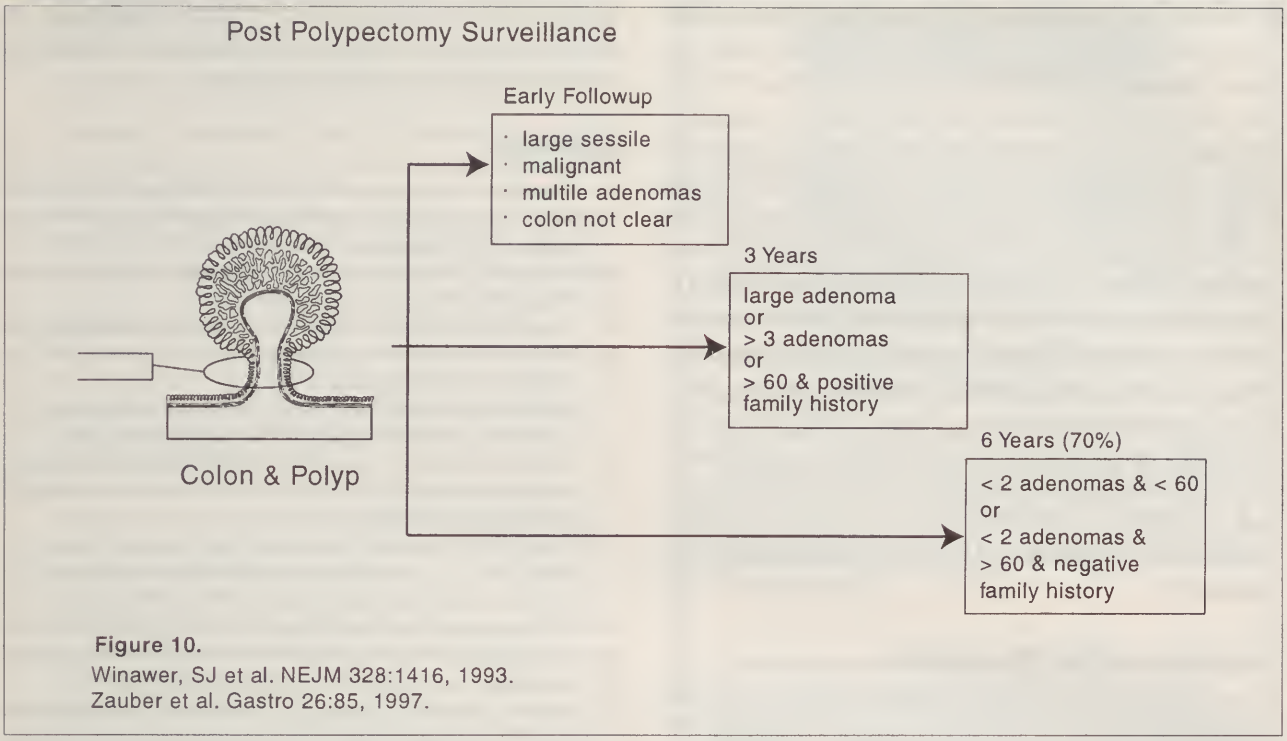


Figure 10.
Winawer, SJ et al. NEJM 328:1416, 1993.
Zauber et al. Gastro 26:85, 1997.

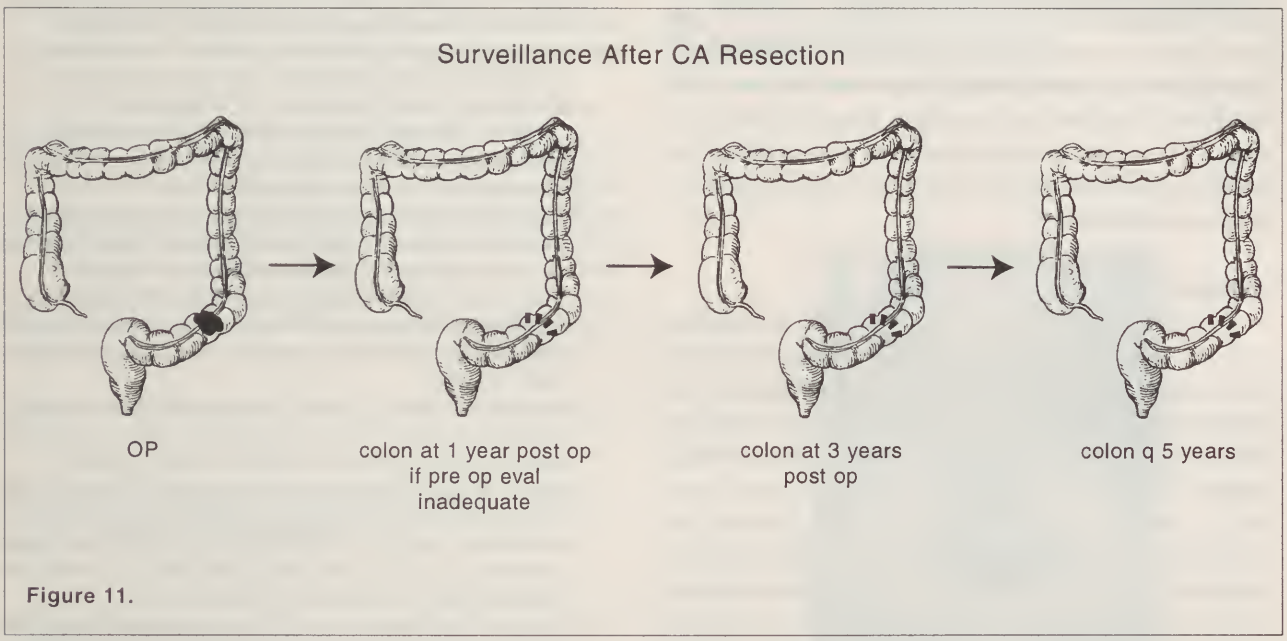


Figure 11.

Disease

The evidence is good that the rate of colorectal cancer development is relative to the duration and extent of the disease. Patients with ulcerative colitis and granulomatous colitis have the same risks. In those patients who have the entire colon involved, colonoscopy should be performed every one to two years after eight years of disease. In those patients who have left sided disease, colonoscopy should be performed every one to two years after fifteen years of duration of disease. (Figure 9) It is common practice to open the dialogue of colectomy early on in patients with refractory disease.

Surveillance After Removal of Adenomatous Polyps

Ideally all adenomas are removed at the time of initial colonoscopy and polypectomy. (Figure 10) Our national organizations have endorsed early followup colonoscopy (1 year) in special circumstances with followup colonoscopy at 3 years. If the 3 year followup is normal, the next examination can be in five years.

Winawer and colleagues, with results of the national polyp study group, have proposed a slightly more detailed scheme of followup which would allow 70% of post polypectomy patients to have the first followup colon in six years, a tremendous decrease in screening costs. They suggest early followup in patients with large sessile or malignant polyps or multiple adenomas. The endoscopist must be confident that a clean colon has been verified. Patients with large adenomas (greater than 1.0 cm. in diameter) or multiple adenomas or patients greater than sixty years old at initial polypectomy with a positive family history should have colonoscopy at three years from the initial observation. Patients with two or less adenomas and less than age 60 or patients with two or less adenomas greater than age 60 with negative family history may be colonoscoped in six years. Double contrast barium enema with flexible sigmoidoscopy is an alternative.

Surveillance after CRC resection

Patients with colorectal cancer (Figure 11) should have a complete examination of the colon within one year after resection if a complete and adequate colonoscopic examination was not performed preoperatively. If this examination is normal, subsequent examination should be offered after three years and then, if normal, every five years. Colonoscopy is the preferred examination, but flexible sigmoidoscopy plus double contrast barium enema is an alternative.

Conclusion

Some of these guidelines represent a departure from the surveillance and screening schedules that we have grown comfortable with over the last decade. It is reassuring that these guidelines have been collated by dedicated experts, have been endorsed by The American Cancer Society, The American College of Gastroenterology, The American Gastroenterological Association, The American Society of Colon and Rectal Surgeons, The American Society for Gastrointestinal Endoscopy, Crohn's and Colitis Foundation of America, Oncology Nursing Society, and Society of American Gastrointestinal Endoscopic Surgeons.[32]

Screening and surveillance of colorectal cancer are cost effective tools in reducing the incidence and mortality of colorectal cancer. Over the last decade, most of our efforts have targeted high risk patient categories. If progress is to continue, we must carry our message to the general population that represents 75% of colorectal cancer patients.

Our message must be heard by churches, synagogues, service clubs and news media. Who knows - in the next decade, we may be dealing with colonic adenomas rather than colorectal cancers.

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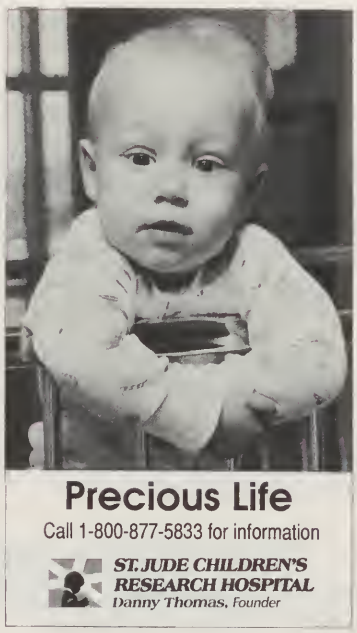
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Editor's Note: This article is the first of a two-part series on colorectal cancer. This article will be followed by "Colorectal Cancer-Chemoprevention" in the September issue of the JOURNAL MSMA.

NATIONAL HIV TELEPHONE CONSULTATION SERVICE

The National HIV Telephone Consultation Service, "Warmline" (800-933-3413) based at San Francisco General Hospital provides free HIV clinical information and case consultation to health care providers. The Warmline faculty includes physicians, clinical pharmacists, and nurse practitioners who have extensive experience treating patients with HIV disease. Warmline consultants are available to answer questions between 7:30 am and 5:00 pm PST. A twenty-four hour voice mail system is available at other times.

The Warmline is funded by the Health Resources and Services Administration, the AIDS Education and Training Centers, and the American Academy of Family Physicians.





Michael H. Carter, Jr., M.D.

The President's Page

Medical Ethics- Core of Medical Practice

The line between black and white is graying. As the practice of medicine grows ever more complex, questions of ethics and professionalism abound. Physicians find themselves facing greater demands to see more patients in less time, and to diagnose and treat them using fewer tests and less money. Some physicians even find themselves in arrangements that place the practice of medicine in the hands of a non-physician management team.

As the gray lines increase, the dynamic medical environment demands a heightened awareness of the ethical issues confronting physicians. I am proud that MSMA and the AMA emphasize mechanisms to work out ethical matters. I know of no function more essential to maintaining the professionalism of the practice of medicine than the arbitration and delineation of a meaningful code of ethics.

At the first meeting of the AMA 150 years ago, the establishment of a code of ethics was one principal item of business. The Council on Ethical and Judicial Affairs (CEJA) is the body now charged with implementing the ethics code. Written to proclaim standards of conduct and ethical behavior identified and adhered to by physicians dating back as far as the Hippocratic Oath, the Principles of Medical Ethics set forth the basic moral tenets for the medical profession. These universal precepts are then interpreted and applied to new situations and protocols as they arise over time. Last year, the AMA renewed its emphasis on medical ethics by creating the Institute for Ethics.

Functioning as an independent academy at the AMA, the Institute for Ethics conducts research in a range of areas in biomedical ethics, publishes scholarly papers and runs educational and outreach programs. The Institute's down-to-earth approach ensures that research on ethics-related policy is of practical value to physicians. The Institute also is about the important business of putting ethical considerations at the forefront of the medical profession.

The AMA Principles of Medical Ethics are a potent, vigorous contract of caring between physicians and patients. Commitment to these principles distinguishes MSMA and AMA physicians from all the others and instills confidence in patients.

Continued page 293

Dear Ms. Shelton, Ms. Evers and Past-Presidents:

Thank you so much for sponsoring my trip to Biloxi for the Annual State Medical Convention. It was great to meet all of the physicians. I learned a lot about how we make policy at the state level, set up some speakers for our lunch meetings next year, and also got some ideas for some service projects for our chapter. On top of all that, I had fun too!

Thank you so much for your continued support of our students. As I learned in Chicago, many other states are not as fortunate as we are in this area.

Sincerely,

DeeDee Price
Student Delegate to MSMA from UMC

Dear members of MSMA:

Please accept my sincere thanks for the Carl Gustav Evers, M.D. Award I received at University Hospital's Honor's Day. I have the highest regard for Dr. Evers' life and achievements, making this recognition all the more special.

I am sorry not to be able to accept the award in person at the Biloxi convention, but we were in Denver at that time making preparations to move. Once again, thank you for this honor. It is a memory I will always treasure.

Sincerely,

Christyne M. Chaudhuri

President's Page continued...

Principles of Medical Ethics

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

3. A physician shall respect the law and recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

5. A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talent of other health professionals when indicated.

6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.



Editorial

JOURNAL OF THE
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Like Herding a Bunch of Cats

This term, "Like herding a bunch of cats," was used recently by a managed care executive to describe his frustration at trying to orchestrate a unified effort from the plan's doctors on a particular point of procedure. Any of us who have ever served as president of a MSMA component society or even chaired a hospital medical staff committee could have spared him his high hopes and subsequent bitter frustration. Independent sorts we are and particularly leery of anyone carrying a briefcase. We chafe over rules and formulas and suggestions and policies. We know a good result, and a bad one as well, when we see one and that a laymen may be quite oblivious to the distinction.

Most of all we know what goes on during a clinical encounter. It can't, for instance, be quantified even by a human, let alone a computer. And, everything depends on the relationship between the doctor and the patient. Because the patient is laying his body and soul out on the table, wide open and vulnerable, for us to do our best, the relationship is among the most intimate and approaches the sacred.

Therefore, when businessmen try to disrupt that relationship in order that they might profit, it is no wonder that we are handled with the same difficulty as are cats. We deny the destruction and swear that things can never be the same. But we misjudge. Such a timeless bond is only temporarily damaged. It rises to reassert itself.

Just recently *Time* magazine and *The Wall Street Journal* published the results of separate polls. Each tabulation says the same. Huge majorities of Americans are distressed over managed care and are worried that doctors aren't being allowed to do their best for their patients. People want the abuses regulated out of managed care by the government.

Regulations people want, and regulations they'll get-- after all, this is an election year. Some years from now these health care plans may face the same bewildering complexity of rules that hospitals and the nuclear power industry now operate under.

This mass social movement by the American people is taking place because of thousands of conversations between doctors and patients in our offices throughout the country. People have turned to us to understand what is happening, and we have told them. You see, we both, doctors and patients, want to preserve our trusting relationship. It is a partnership as natural as the wind and it has taken place, thankfully, without committees and boards-- just patients and doctors talking to each other from the heart like we always have. Yes, thankfully, we herd just like a bunch of cats.

-Leslie E. England
Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

For over 27 years, we've been the **Mississippi Foundation for Medical Care.** But healthcare has evolved. And so have we.

Today, our enhanced data collection and analysis capabilities combined with our quality improvement processes are helping physicians and providers, payors and patients all work together. With this evolution comes new commitment and a new name.

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An Interview with MSMA Executive Director William F. Roberts

Karen A. Evers

Bill, let's start at the beginning. Where did you grow up? Tell me about your upbringing?

I was born and raised in Pascagoula. My father was a teacher and public school administrator who later went to work for Ingalls Shipbuilding Corporation during the 1940's. He retired from there after about 33 years and passed away in 1990. My mother, like most women at that time, was a housewife who took care of the family and our home. She still lives in Pascagoula in the home I grew up in. I have an older brother, a retired Air Force officer, who now lives and works in the Atlanta area. My upbringing was about as typically middle-class as you can get. The church was probably the most dominant influence during the first eighteen years of my life and being raised in that kind of environment was the most important thing my parents did for me.

You went to Ole Miss, majoring in sociology with a psychology minor. What were the deciding factors leading you to law school at Mississippi College?

I wish I could tell you it was because I had this life-long ambition to be a lawyer, but that's not true. Actually, when I finished school at Ole Miss I served two years in the Army because I was in ROTC, and when that was over and I started looking for a real job I realized I had no marketable commercial skills. I had never really given much thought to what I was going to do when I graduated from Ole Miss because I assumed I would be a career Army officer. I was pretty gung-ho then, but spending a year in Vietnam changed all that. It didn't take me long to figure out that I needed some additional education if I was going to get any kind of decent job.

So I decided to get a law degree. Fortunately, because of my service in Vietnam I was eligible for the G.I. Bill, which paid for me to attend law school at night while I worked during the day.

You worked for Blue Cross-Blue Shield and then the Mississippi Medicaid Commission while you were earning your Juris Doctor. Wasn't that a difficult challenge?

Although I started law school when I was with Blue Cross, during most of the three years it took me to finish I was working for the Medicaid Commission. Dr. Alton Cobb was Director of the Commission and he used to occasionally catch me studying or briefing cases when I should have been doing Medicaid work. Fortunately, he was very understanding and supportive. All in all, working eight hours a day and going to school three nights each week for three hours every night is not something I would want to do again. The routine got real old, but I had no choice at that time. Going to law school full-time at Ole Miss simply wasn't an option at that point in my life.

Then you joined MSMA as Legal Counsel and Director of Government Affairs. How did that happen? Charlie Mathews was Deputy Director of the Medicaid Commission when I went to work there in 1971 and we became good friends. In 1972 he was named Executive Director of MSMA and about a year or so later when I finished law school he asked me to join the association's staff as it's first in-house legal counsel and full-time lobbyist. I had been working with some members of the legislature while I was with the Medicaid Commission and really liked the idea of being a lobbyist, so I jumped at the opportunity.

You were with the association when it formed



MSMA Executive Director Bill Roberts and his wife, Marilyn, at the 130th Annual Session President's Dinner.

Medical Assurance Company in 1977. What role did you play in that effort?

Well, 1976 was the year of the "big" medical malpractice insurance crisis. Medical liability carriers all across the country were pulling out of the business, increasing premiums three and fourfold, or switching to a "claims-made" type policy. In response, many state medical associations began to organize their own malpractice insurance companies, and the AMA even formed a reinsurance company to assist the states who were doing so. Charlie and I, after talking with our physician leadership, decided that we needed to do something to bring some element of stability to the medical liability insurance market in Mississippi. So we worked with our outside legal counsels, the late Milton Case and his partner at that time, Bob Montgomery, and some insurance consultants out of North Carolina, and came up with a plan to create our own non-profit insurance company. We enlisted the involvement of Dr. Faser Triplett as our spokesperson and went all over the state trying to sell memberships in the company to physicians for $1,000. We eventually raised about $750,000 and received approval from Insurance Commissioner George Dale to commence business. Thus began what was initially called the Mississippi Medical Fraternal and Educational Society. When we actually started writing coverage I was the chief cook and bottle washer because we couldn't afford to hire any full-time staff until we had some premium income. I did the underwriting, issued the policies, collected the premiums, made bank deposits and kept the books. I even went out and retained an attorney, Jimmy Reynolds, to defend our first claim. After awhile, Charlie hired a real insurance professional, Mike Houpt, to run the company and Mike and Dr. Triplett brought it to where it is today.

Why did you leave MSMA in 1978 to go to work at the University of Mississippi Medical Center?

Well, it wasn't because I was unhappy at the association. The Vice Chancellor of the medical center, Dr. Norman Nelson, called me one day and said that the Assistant Vice Chancellor, Dr. David Wilson, was retiring and he wanted to know if I would be interested in taking his place. We talked about it a couple of times after that and I eventually decided it was a good opportunity. When you're young I think you always feel the grass is greener on some other hill. I was also entranced with the idea of working for my alma mater. So I left MSMA. After I had been at the medical center for a few months I realized that I was not well-suited for academia. After the wheeling and dealing of lobbying for five years I found the pace at the medical center just a little too slow. So after two years I decided not to renew my contract and left.

You then began practicing law. Did you specialize in medical-related issues?

Actually, no. Oddly enough, I spent the whole four years doing oil and gas work. Mostly because there was a tremendous oil boom in the early 1980's and there was a lot of work to be had. It was also where the money was.

Where did you meet your wife, Marilyn?

We met while I was working at the medical center. She was the budget officer for the campus. I had a lot of good experiences during my two years there, like getting to know your dad really well, but the best thing about my time there was meeting Marilyn. We have a daughter, Allison, who is twelve. I also have two daughters from a previous marriage. The oldest, Rachael, is a senior at Ole

Miss and the younger one, Robyn, is a sophomore at Southern Miss.

MSMA is certainly fortunate to have someone with your experience who has worked for the AMA. How did you end up there?

In 1983 the oil boom had started to play out and I needed to reassess where my career was going. I decided that I wanted to get back into organized medicine, particularly at the national level. I still knew some people at the AMA, so I made a couple of contacts and so did Charlie. Eventually they offered me a position on the Medical Society Relations staff as a Field Representative and Marilyn and I decided to move to Chicago. As a Field "Rep." I was the liaison with about 13 state medical associations and spent a lot of time traveling all over the country.

And then you became Director of the Department of State and County Relations.

A little less than a year after I had been with the AMA they decided to split the Division of Medical Society Relations into two departments - one for states and counties and another for national specialty societies. There were six of us on the staff who covered the states and counties and two who covered the specialties. I was made the Director of the Department of State and County Relations.

Then later you went to the AMA's Washington, D.C. office as Legislative Counsel. Was that something you aspired to do and what was it like to work in that kind of political environment?

When I was in the Chicago office our primary responsibility in working with the states and counties was in the area of grassroots legislative advocacy. My department wrote the AMA's manual on developing grassroots advocacy programs at the local level and we worked with the states in setting up and using those programs to support the AMA's advocacy efforts in Washington. During the process we worked very closely with AMA's Washington Office staff and when the position of Legislative Counsel became vacant some of the lobbyists asked me if I would consider it. I said I would and shortly after that the head of the Washington Office, Dr. John Zapp, (now the Executive Vice President of the American Dental Association) called and offered me the position. So about eighteen months after moving to Chicago from Jackson, the AMA moved us to Washington, D.C. If you really enjoy politics and the legislative process, working there is an unforgettable experience. It was very stressful and we used to put in some long hours, but it was never dull or boring.

After being in Washington, D.C. only ten months you moved back to the AMA's Chicago office as Director of the Division of Medical Society Relations. You were also assigned the responsibility of implementing the AMA's Health Policy Agenda for the American People.

I really liked Washington and didn't want to leave, but the AMA asked me to return to Chicago to head up the Division of Medical Society Relations, where I had started less than three years earlier. Additionally, they wanted me to organize a staff to implement the Health Policy Agenda for the American People project. This was a major collaborative effort with business, labor unions, consumer groups and other health related organizations that had cost the AMA about $5 million and taken several years to develop. The final product consisted of about 180 recommendations on every aspect of our health care delivery system. They asked me to assume the responsibility for developing a collaborative plan to implement the recommendations, which proved to be like throwing jello against the wall and getting it to stick. We soon learned that the only group that really cared about implementing the recommendations was the AMA and that a consensus decision-making process among numerous groups does not always result in a total buy-in by the participants. The whole effort wasn't very successful, I'm sorry to say. It was another well-intentioned project by the AMA that simply didn't achieve the results that were intended.

In 1989, five and a half years after joining the AMA, you returned to Mississippi and became MSMA's Assistant Executive Director and General Counsel. How did that come about?

I was really fortunate during the time I was with the AMA. For whatever reason, the people at the top level of the staff - Dr. Sammons, Joe Miller, Whalen Strobhar and Wayne Bradley - all took me under their wing and I was promoted three times in less than three years. Career-wise, things were really moving much faster than I had ever expected when I went there. But after awhile Marilyn and I just got really homesick. We both had family back here whom we missed a great deal and living in Chicago was just wearing us down. Chicago is an absolutely wonderful city - maybe the best in the entire country - but if you're a Southerner the winters are just absolutely brutal. So we decided to move back to Mississippi. I had a couple of business opportunities with Marilyn's family

that I planned to pursue and we figured we would just be poorer, but happier. Not long after I had given the AMA notice that I as leaving, Charlie called me in Chicago to say that Bucky Murphy was leaving to go into business for himself. He said this was an opportunity to come back to MSMA if I wanted to and I agreed to do so without hesitation.

What initiatives do you believe are important to the future of MSMA as we move towards the millennium?

Medical societies, including MSMA, are only going to survive if they continue to have some relevance to a physician's practice environment - whatever it might be. If we don't provide some recognizable value to the physician for his or her membership dues dollar, then we aren't going to make it. The whole environment surrounding the delivery of health care has changed so much during the past few years that the challenge for those of us who work in organized medicine has been to identify those services that make us relevant to a physician's practice and professional environment. To do that we need to be able to do two things very well - one is to represent the common interests of physicians and protect their ability to provide quality medical care to their patients, and we have to do it wherever that ability is being challenged, whether its with a legislative body, a regulatory agency or a health insurer. Secondly, we have to provide physicians with the tools to not only survive in their chosen practice environment, but to thrive. If we can do that, then it will be good for physicians, and correspondingly good for patients. For the past several years I think organized medicine has spent too much time talking about being the patient's advocate when we should have spent more time being the physician's advocate. Medical associations aren't unions by any means, but we both have members whom we attempt to serve. Can you imagine the United Auto Workers spending all its time talking about being the car buyer's advocate? Not hardly. Organized medicine does have an obligation to protect the health of the public, but I believe that by appropriately representing the interests of ethical physicians we can also protect the rights of patients to receive the medical care that they need. We must also continue to resist any and all efforts to transform the delivery of health care to a commercial enterprise where you focus solely on the product and its cost. The physician-patient relationship is the heart and soul of medicine and that is what sets health care apart from the normal commercial transaction. Those of us who work in organized medicine are the keepers of that flame and we must ensure that it continues to burn bright.

Calling All MSMA Physician/ Photographers

• Seeking photographs taken by physicians for publication as 1999 JOURNAL MSMA covers.

• Grab your camera. Shoot landscapes, people, animals, or anything else you can capture on film. Photographs of subjects relevant to Mississippi will be given strong consideration.

• The Committe on Publications will judge the entries on the merits of quality, composition, originality and appropriateness to the JOURNAL MSMA and select the top ten best cover photos.

• Specifications: Color slides and photos only. Size: approximately 5 by 7 " or 8 by 10." Vertical format photos are preferred.

• Deadline: October 1, 1998

Send entries with a brief description of the subject, as well of yourself, to:
Karen Evers, managing editor,
JOURNAL MSMA,
Mississippi Medical Association,
735 Riverside Drive,
Jackson, Mississippi, 39202.

For more information, contact Ms. Evers at (800) 898-0251, extension 412, or (601) 354-5433.

"Head Stuff"

I recently read an editorial about the weather in which a man who loves summertime was castigating the weather reporters for making us feel so bad about hot summer weather. He explained that Mississippi is supposed to be this way. It is good for certain seasonal businesses; it is good for morale; and it is good for us health-wise. It makes us the hearty people that we are. So, don't make us feel bad about the weather. Let's rejoice in the beauty of summer and stop complaining.

Then I ran across a humorous story that reminded me how we are responsible for many of our feelings. A chronic complainer goes into a diner and has a seat. The man begins fretting that it is too hot in the diner. Finally, the man calls a waiter over and complains, "It's too hot in here, turn down the air condition thermostat!" The waiter replies, " Of course, sir, whatever you say." A few minutes later the man is upset because now he is too cold. Again he calls the waiter over: "Now it's too cold, turn up the thermostat." Again the waiter replies, "Of course sir, whatever you say." This happens several more times. In wanting to be empathetic with the waiter, a bystander says to the waiter, "He must be driving you crazy, getting you to turn the thermostat up and down all the time." The waiter replies, " Him drive me crazy? Nonsense! I'm driving him crazy, I haven't been touching the thermostat!"

A lot of our feelings are in our heads. We can be happy if we choose to be regardless of conditions around us. So much of life is in our heads. We have the power to live more fully with joy, or squander it with worry, self-pity or anger. Our happiness does not depend upon the weather or conditions of our environment, but upon the way we react to stuff that happens to us. Shift happens.

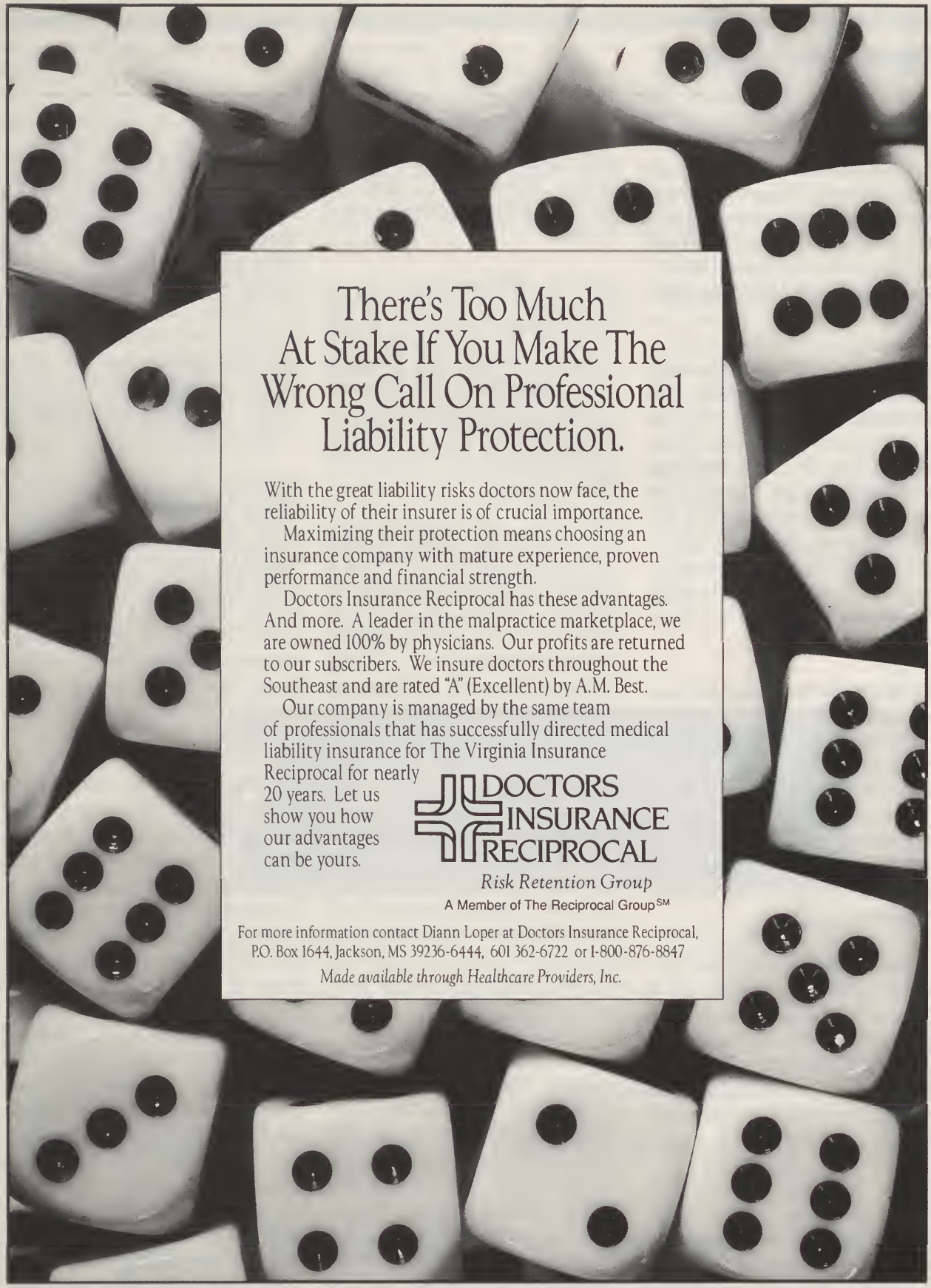
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Take a Look

The Health Care Financing Administration (HCFA) has an informative and comprehensive homepage at URL www.hcfa.gov. Useful information such as statistics and data, publications, laws and regulations, and billing instructions can be accessed at this site. In addition, HCFA has added a new site to its homepage that provides information on the Balanced Budget Act (BBA) of 1997. Go to the site by clicking on the Balanced Budget Act button on HCFA's homepage. One of the most significant BBA changes to the Medicare program is the coverage of more preventive benefits. A review of this information as well as how to bill Medicare can be found in the BBA site under Prevention Benefits, Physician & Provider. The Medicare + Choice information is available in this site, which explains statutory requirements and regulation implementation regarding HCFA's authority to contract with a greater variety of managed care and fee-for-service plans.

And don't forget to visit I.Q.H. at www.iqh.org.

-James S. McIlwain, M.D.


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New Members

Ahmed, Nazia, Hattiesburg. Born Pakistan, September 9. 1967; MD Aga Khan University Medical College, Pakistan 1992; one year residency St. Luke's Roosevelt Hospital Center, New York, New York; internal medicine, same, 1995-97; elected by South MS Medical Society.

Becker, Robert C., Tupelo. Born Kihery, Maine, July 17, 1964; East Tennessee State University Quillen-Dishner College of Medicine, Johnson City, TN, 1991; radiology residency, Michigan State University Affiliated Hospitals, Flint, MI, 1992-96; neuro radiology fellowship, University of Alabama at Birmingham, Birmingham, AL, 1996-98; elected by Northeast MS Medical Society.

Burkhartt, Barbara A., McComb. Born Minneapolis, MN 1953; MD University of South Alabama School of Medicine, Mobile, AL, 1992; interned, internal medicine residency and cardiology fellowship, University of South Alabama Medical Center, Mobile, AL, 1992-98; elected by South Central Medical Society.

Clayton, Todd A., Meridian. Born May 2, 1966; MD University of Mississippi School of Medicine, Jackson, MS 1993; family practice residency, University of Tennessee Medical Center, Memphis, TN, 1993-96; elected by East MS Medical Society.

Cougle, Allan G., Gulfport. Born Munich, Germany, April 1, 1948; MD Louisiana State University School of Medicine, New Orleans, LA, 1972; pediatric residency, Charity Hospital, New Orleans, LA, 1972-75; pediatric cardiology fellowship, Duke University Medical Center, Durham, NC, 1982-85; elected by Coast Counties Medical Society.

Elwood, William Scott, Petal. Born Gary, IN, November 25, 1950; MD Eastern Virginia Medical School , Norfolk, VA, 1984; one year internship, Naval Hospital, Oakland, CA; family medicine residency, Naval Hospital, Charleston, SC, 1988-91; elected by South MS Medical Society.

Frye, George R., Meridian. Born Meridian, MS, June 27, 1962; MD University of Mississippi School of Medicine, Jackson, MS, 1988; interned one year, Baptist Medical Center Birmingham, AL; radiology residency University of Tennessee Medical Center, Knoxville, TN, 1989 - 1993; elected by East MS Medical Society.

Guynes, Richard D., Jackson. Born Stutgart, Germany, August 6, 1965; MD University of Mississippi School of Medicine, Jackson, MS, 1991; internal medicine residency and cardiology fellowship, University Medical Center, Jackson, MS, 1991-98; elected by Central Medical Society.

Hatzis, Nick. Born New York, March 28, 1966; MD University of South Florida School of Medicine, Tampa, FL, 1991; orthopedics residency, Louisiana State University Medical Center, New Orleans, LA, 1991-96; shoulder surgery fellowship, University of Texas Medical Center, San Antonio, Tx, 1996-97; elected by Coast Counties Medical Society.

Jaksha, Matthew M, Jackson. Born Fremont, NE, April 27, 1967; MD Creighton University School of Medicine, Omaha, NE, 1993; radiology residency, University of New Mexico School of Medicine Medical Center, Albuquerque, NM, 1993-97; nuclear medicine fellowship, Mallinckrodt Institute of Radiology, Washington University, St. Louis, MO, 1997-98; elected by Central Medical Society.

Mackey, Richard L., Oxford. Born Brooklyn, NY, September 18, 1957; MD Howard University College of Medicine, Washington, DC, 1988; internal medicine residency, LAC/USC Medical Center, Los Angeles, CA, 1988-91; anesthesiology residency, Martin Luther King, Jr.,/ Drew Medical Center, Los Angeles, CA, 1995-97; elected by North MS Medical Society.

Manton, James S., Hattiesburg. Born Columbia, MS, May 5, 1969; MD University of Mississippi School of Medicine, Jackson, MS, 1995; internal medicine residency, University of Tennessee Medical Center, Chattanooga, TN, 1995-98; elected by South MS Medical Society.

Marrogi, Aizen J., Hattiesburg. Born Iraq, February 7, 1957; MD University of Baghdad, Baghdad, Iraq, 1981; internship & pathology residency, William Beaumont Hospital, Royal Oak, MI, 1984-86 and Grand Rapids Area Medical Educational Center, Grand Rapids, MI, 1986-88; dermatopathology fellowship, St. John Mercy Medical Center and Barnes Hospital, St. Louis,

MO, 1989-90; elected by South MS Medical Society.

Morris, Jeffrey A., Hattiesburg. Born Jackson, MS, November 28, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1994; internal medicine residency, University of Mississippi Medical Center, Jackson, MS, 1994-97; elected by South MS Medical Society.

Moore, Merwin B., III, Hattiesburg. Born Columbia, MS, April 22, 1958; MD University of Mississippi School of Medicine, Jackson, MS, 1986; internship one year, Louisiana State University Medical Center, New Orleans, LA, 1986-87; general surgery residency 1987-88, same; orthopaedic surgery, same, 1989-94; elected by South MS Medical Society.

Patel, Amita N., Greenville. Born India, June 20, 1953; MD Government Medical College, Surat, India 1977; interned and internal medicine residency, Long Island Jewish Medical Center, New Hyde Park, NY, 1990-93; nephrology fellowship, Same, 1993-95; elected by Delta Medical Society.

Scalzo, David, Jackson. Born Danbury, CT, September 6, 1957; MD University of Connecticut School of Medicine, Farmington, CT, 1984; surgery internship, University of California Medical Center, San Diego, CA, 1984-85; neurosurgery residency, Same, 1985-87; radiology residency, University of California, Irvine, CDA 1989-93; fellowship interventional & diagnostic neuroradiology, University Utah, Salt Lake City, UT, 1993-95; elected by Central Medical Society.

Stevens, Carl W., II, Laurel. Born Baton Rouge, LA, April 6, 1967; MD Louisiana State University School of Medicine, Shreveport, LA, 1989-93; otolaryngology, head and neck surgery residency, University of Texas Medical Center, Galveston, TX, 1993-98; elected by South MS Medical Society.

Sullivan, Wm. David, Laurel. Born Oxford, MS, January 4, 1964; MD John Hopkins Medical School, Baltimore, MD, 1992; interned one year, Parkland Memorial Hospital, Dallas, TX; internal medicine residency, University of Texas, Southeastern Medical School, Dallas, TX, 1993-95; cardiology fellowship, Tulane University Medical Center, New Orleans, LA, 1995-98; elected by South MS Medical Society.



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Westmoreland, Terry A., Columbus. Born Columbus, MS, August 11, 1965; MD University of Alabama School of Medicine, Birmingham, AL, 1991; interned and internal medicine residency, National Naval Medical Center, Bethesda, MD, 1991-95; dermatology residency, University of Alabama Medical Center, Birmingham, AL, 1995-98; elected by Prairie Medical Society.

Wilson, Mark E., Jackson. Born NY, NY, April 18, 1957; MD Wayne State University Medical School, Detroit, MI, 1987; interned one year and internal medicine residency, St. Joseph Mercy Hospital, Ann Arbor, MI, 1987-90; gastroenterology fellowship, Michigan State University, Lansing, MI, 1990-93; elected by Central Medical Society.

DEATH:

Watkins, Clyde A., Jakcson. Born Aberdeen, MS, July 24, 1916; MD Tulane University School of Medicine, New Orleans, LA, 1940; interned Charity Hospital New Orleans, LA, 11/40 - 6/42; resident in TB & Chest Diseases, MS State Sanatorium, Sanatorum, MS, 1945-47; member of Central Medical Society; died June 25, 1998, age 81.

Beth Hoskins, M.D., professor of pharmacology and toxicology at UMC, until her death from cancer on April 15, received the American Medical Association's Innovations in Medical Education posthumously. **Dee Dee Price,** a third-year medical student, accepted the award at the AMA meeting June 13 on behalf of the Medical Center and as a representative of all the students who nominated Hoskins for the award before her death. The award was given to UMC Vice Chancellor Dr. Wallace Conerly who, in turn, presented the award to Hoskins' sister Elaine Cox of Gautier. Hoskins taught medical students the names of hundreds of drugs and their possible side effects and interactions with other drugs by drawing original cartoons and having the students color them with her. He faculty colleagues are seeking a publisher for her book, *Pharmacology in Cartoons and Colors*.

John Bower, M.D., professor of medicine and director of renal disease and the Artificial Kidney Unit at UMC, was selected by the School of Medicine at the Medical College of Virginia to receive the 1998 Medicine Star Award for humanitarian and professional achievements and community service.

Nancy Tatum, M.D., associate professor of family medicine and co-chair of the Clinical Ethics Committee at UMC, was honored by the Mississippi Academy of Family Physicians with an HIV-AIDS Outstanding Service Award during a ceremony at the Jim Buck Ross Agriculture and Forestry Museum Music Hall of Fame.

Joe Clark Files, MD, professor of medicine and director of hematology at UMC, was chosen to receive the coveted "1998 Teacher of the Year Award" by the UMC medicine residents. Dr. Files was described as a "true teacher" because he is "someone who in his daily interactions teaches each of us the importance of medical knowledge tempered with humility, compassion, and a never-ending desire to help and heal."

Michael J. Bone, M D., Assistant Clinical Professor in the Department of Ophthalmology at the University of Mississippi School of Medicine in Jackson recently published a chapter titled "Retinal Detachment" in *Ophthalmology Secrets*. The book provides answers to some of the most frequently asked questions in the field of ophthalmology. He also has a research article appearing in an upcoming edition of the peer reviewed journal, Annals of Ophthalmology. The article is titled "Factors Associated with Rhegmatogenous Retinal Detachment." Dr. Boone is an ophthalmologist specializing in diseases and surgery of the retina |and vitreous. He is in private practice with Mississippi Retina Associates. P.A. in Jackson.

William B. Geissler, M.D., associate professor of orthopaedic surgery and chief of the sports medicine and shoulder services at the University of Mississippi Medical Center, recently served as moderator of the Wrist Arthroscopy Instructional Course, for the annual American Academy of Orthopaedic

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

Surgeons meeting in New Orleans this year. Dr. Geissler spoke on arthroscopic management of carpal instability. He also spoke on arthroscopic management of intraarticular fractures of the distal radius as a participant on the instructional course on fractures of the distal radius. In addition, he served as a panelist for a symposium on fractures of the distal radius during the same meeting. Dr. Geissler, also spoke at the University Physician's Conference Symposium in Oxford, on treating the everyday athlete. Dr. Geissler spoke on sports medicine injuries of the upper extremity.

Felix H. Savoie, III, M.D., recently gave five scientific presentations at the VI Congreso Argentino De Arthroscopia III Encuentro Latino Americano in Buenos Aires, Argentina. His talks were entitled "Arthroscopic Rotator Cuff Repair", "Shoulder Arthroscopic Management of Multidirectional Instability", "Arthroscopic Management of Lunotriquetral Instability", "Diagnostic Elbow Arthroscopy", and "Arthroscopic Management of Arthritis of the Elbow."

Larry D. Field, M.D. recently served as a faculty member at a shoulder surgery course sponsored by the American Academy of Orthopaedic Surgeons entitled "Open and Arthroscopic Shoulder Surgery: Advanced Techniques." Dr. Field demonstrated various surgical techniques at the meeting and gave two talks entitled "Arthroscopic Shoulder Surgery: Indication and Technique" and "Open Rotator Cuff Repair: Diagnosis and Techniques." He also recently attended and participated in a scientific meeting focusing on recent advancements in shoulder and elbow surgery sponsored by the American Shoulder and Elbow Society and the American Academy of Orthopaedic Surgeons. Dr. Field gave a presentation entitled "Arthroscopic Versus Open Stabilization for Recurrent Shoulder Instability."

Claude D. Brunson, M.D., associate professor of anesthesiology at UMC, was selected for inclusion in the listing of the Best Doctors in America. The list, which serves as a resource to patients, is based on a survey in which more than 35,000 doctors throughout the country are asked to rate the clinical abilities of other doctors in their area of specialization. Only those physicians who earn the consensus of their peers for superior clinical abilities are included.

Hubert E. Spears, Jr., M.D., FACS, of Oxford, recently received a three-year appointment as cancer liaison physician for the Cancer Program at Baptist Memorial Hospital-North Mississippi in Oxford.

Daniel W. Jones, M.D., professor of medicine and director of the Division of Hypertension at UMC, was selected by the American Heart Association (AHA) to represent the Council for High Blood Pressure Research at the AHA and National Coalition for Heart and Stroke Research Lobby Day in Washington, D.C.

John C. Morrison, M.D. of Brandon was honored recently at the 18th Annual Meeting of the Diabetes Foundation of Mississippi, Inc., (DFM). Each year during the awards luncheon volunteers are honored for their contributions to the DFM and for their continued support in "the fight against diabetes." The DFM Annual Meeting provides education for adults, children, and family members on current diabetes research and information on new technology. This year's meeting included speakers from Jackson, Hattiesburg, and Meridian and focused on new diabetes treatments, and diabetes care from head to toe.

A. Wallace "Wally" Conerly, a Tylertown native, was the guest speaker at Delta State University's commencement in Cleveland. Dr. Wallace is vice chancellor for health affairs and dean of the School of Medicine at the University of Mississippi Medical Center in Jackson. He is a professor of medicine and was director of the department of respiratory therapy in University Hospital for 21 years.

J. Turner Wright, M.D. is a new member of the Medical Staff at Northwest Mississippi Regional Medical Center. Dr. Wright is an Otorhinolaryngologist.

John McFadden, M.D. of Tupelo received an award and spoke at the first March Against Pain in Washington, D.C. The march, sponsored by the American Society for Action on Pain and the National Foundation for the Treatment of Pain was held at the U.S. Capitol. The purpose of the march was to make Congress and the public aware of the under-treatment of pain patients by doctors who fear being prosecuted or losing their license for prescribing opioids.



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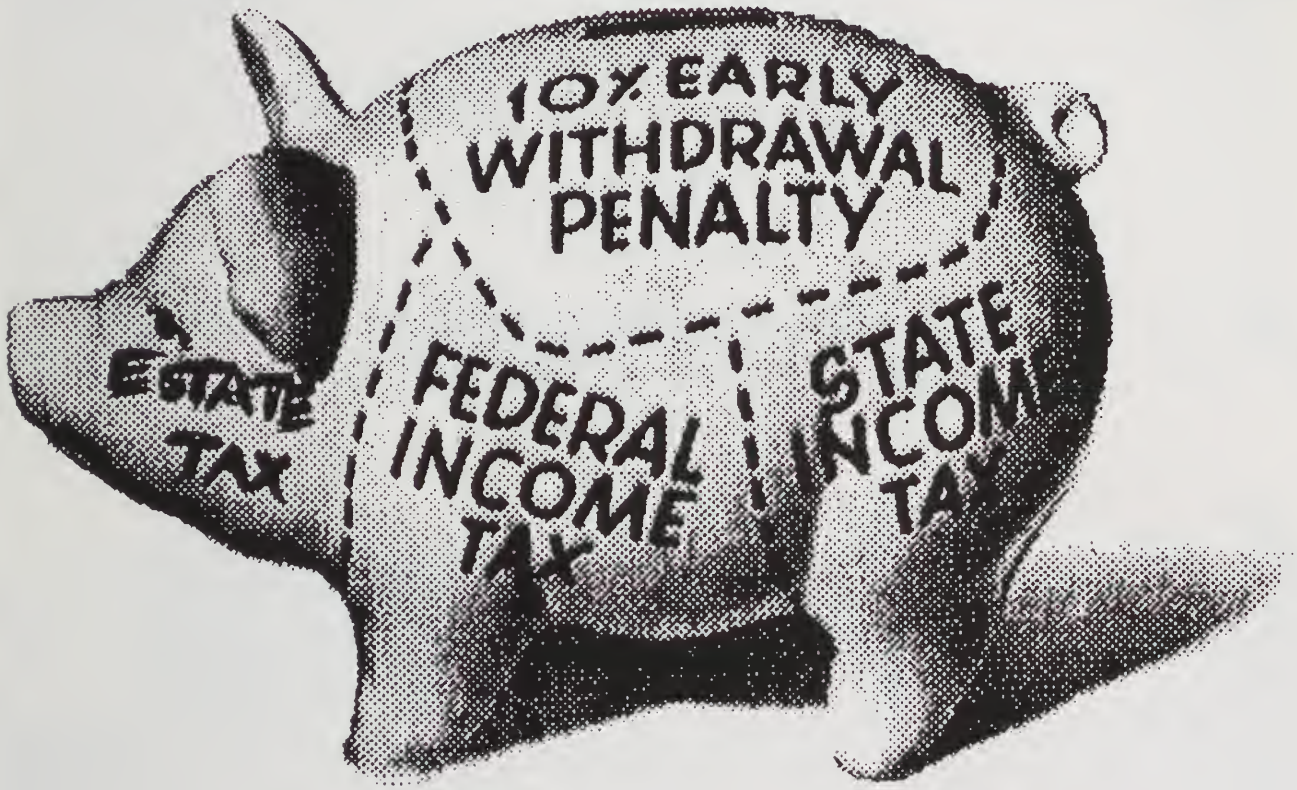
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SEPTEMBER 1998

SCIENTIFIC ARTICLES

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Colorectal Cancer-Chemoprevention

SPECIAL ARTICLES

Coding Concepts

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Reduction Mammaplasty by the Inferior Pedicle Technique

William O. B. Thompson, M.D.
William H. Wallace, M.D.
Robert Allen Smith, M.D.
Kenneth R. Barraza, M.D.
Stephen F. Davidson, M.D.
James T. Thompson, II, B.S.

Abstract

A retrospective study of 350 reduction mammaplasties by the inferior pedicle technique performed over a 3 year period allows a critical evaluation of post-operative complications, results, and patient satisfaction. The procedure can be done in a timely manner on an outpatient basis and is applicable to breasts of different shapes and sizes. The rate of post-operative complications (5%) was comparable to previous studies. Patient satisfaction was high (98%) with near-total relief of preoperative symptoms. Concern about the resultant scars was low (2%) when the incisions followed the natural contour of the breast.

Introduction

Since Godfrey, et al, reported in 1977 to this journal on the surgical management of large breasts, reduction mammaplasty has become a common plastic surgery procedure[1]. Despite overwhelming patient acceptance, third party payors have questioned the appropriateness and efficacy of this surgery. Among plastic surgeons, debate over technique and patient selection continues to complicate the ability to obtain meaningful data supporting the procedure. During the three-year period, 1994 to 1996, four members of our group performed 350 reduction mammaplasties, 333 or 95% by the inferior pedicle technique and 17 or 5% using a free nipple graft technique. A large number of cases done by a limited group of surgeons using the same technique offers an ideal opportunity for evaluation of indications, postoperative results, complications, and patient satisfaction. An in-depth review of the cases was recently published by Wallace, et al [2].

Our patient population was 60% white and 40% non-white with an average age of 32 years. The average weight of our patients was 167 pounds. The following most common complaints were fairly uniform with our patients [table 1]: neck pain, shoulder pain, and limitation of physical activity. To a lesser degree were complaints of upper back pain and difficulty with clothes fitting. Approximately half of our patients complained of rashes under the breasts or between the breasts. The most common physical findings included heavy pendulous breasts, shoulder grooves and, to a much lesser degree, intertrigo [table 2]. Approximately one-third of our patients had significant asymmetry between the breasts.

Technique

The operative technique used in this study preserves blood flow to the nipples during the breast reduction by leaving them attached to central segments of the breast tissue [3,4,5]. This segment (the pedicle) is based just above the inframammary crease so as to include one or

TABLE 1
Pre-operative Complaints

Neck pain	97%
Shoulder pain	97%
Limitation of activity	97%
Back pain	87%
Difficulty with clothes fitting	87%
Rash under breast	51%

TABLE 2
Pre-operative Physical Findings

Shoulder grooves	83%
Intertrigo	38%
Asymmetry	32%

TABLE 3
Post-operative Complications

Fat necrosis	8%
Hypertrophic scar	8%
Epidermolysis	7.7%
Infection	4.3%
Nipple/areolar necrosis	
partial	4%
total	0.5 %
Skin necrosis	1.7%

TABLE 4
Patient Satisfaction

Relief of pre-op symptoms	98%
Patient would undergo procedure again	98%
Complaint of scarring	2%

more perforating branches of the intercostal blood vessels. Only rarely in the case of extremely large breasts is it necessary to remove the nipples and re-graft them on the reduced and reshaped breasts.

Surgery is generally planned with the patient in the upright position and the breasts marked prior to surgery. In an effort to increase efficiency and decrease operative time, the breasts are operated on simultaneously by two surgeons. All decisions affecting the size and symmetry of the breasts are made by the primary surgeon. Most of the excess skin is removed from the inferior aspect of the breast and through this access the desired amount of breast tissue is resected, preserving the pedicle. The wound closure leaves an incision scar in the inframammary crease, a central vertical scar extending from the inframammary crease to the areola and a scar around the areola.

Study Methods

This is a retrospective study accomplished by a detailed review of more than 400 clinic patient records and additional information from outpatient surgery and hospital records. Only those 350 female patients who had bilateral reduction mammaplasties during the period 1994-1996 were included in the study. The information obtained from these records was analyzed using a computer database management system.

Results

Evaluation of the data from these 350 cases revealed an average operative time of 1 hour and 25 minutes. The average weight of resected breast tissue was 975 grams per breast with a range of 250 grams to greater than 2000 grams per breast. The pathologic findings on tissue removed with the reduction showed no evidence of malignancy in any of our 350 cases. However, there was a 27% incidence of fibrocystic disease and a 3% incidence of some atypical ductal changes.

Those patients requiring secondary operations were considered significant complications and involved 17 cases out of the 350 or a 5% rate of significant complications which is comparable to previous studies[6]. Of these 17 cases, six involved excision of symptomatic fat necrosis while five cases were scar revisions. When looking at our overall postoperative problems [table 3], it is noted that 8% of patients had some evidence of either fat necrosis or hypertrophy of their scars. There was slightly lesser incidence of epidermolysis (7%) but a very low rate of actual skin necrosis (1.7%). There was a 4% incidence of partial or spotty necrosis of the nipple-areolar complex, but only two nipples out of 700 had total necrosis

and loss. Both of these cases involved older women who were smokers and were not directly related to pedicle length.

Among the 36 patients who were smokers, three patients or 8% had significant areas of fat necrosis. This was the same as the incidence of fat necrosis among our general population of breast reduction patients. However, when looking at skin necrosis, an 8% incidence among smokers was four times greater than the incidence of skin necrosis among the general group. Therefore, patients are encouraged to stop smoking at least two weeks prior to surgery. Evaluation of postoperative nipple sensation revealed that approximately 9% of patients had decreased nipple sensation at one week after surgery. However, at three months this dropped to 5.4%.

Patient satisfaction was extremely high with the surgery, a finding consistent with recent reports[7,8]. Most patients (98%) related a relief of preoperative symptoms, and most stated they would undergo the procedure again [table 4]. Although there is much discussion about limiting the scars of reduction mammaplasty, only 2% of patients had complaints concerning the scarring.

Of significant interest in this age of managed care is a look at the costs of this procedure. During the early stages of the three-year period some of these cases were done at the hospital as a 23-hour observation. The average facility expense to the insurance company for these cases was between $4100 and $5000. Over the last two years of the study, however, essentially all of the cases were performed at a free standing outpatient surgery facility either as complete outpatients or in a 23-hour observation setting. The cost is a fixed fee of $1320 for strict outpatient with an additional $350 added for the 23-hour observation, a significant savings over the previous hospital setting with no added risks, as reported by others[9,10].

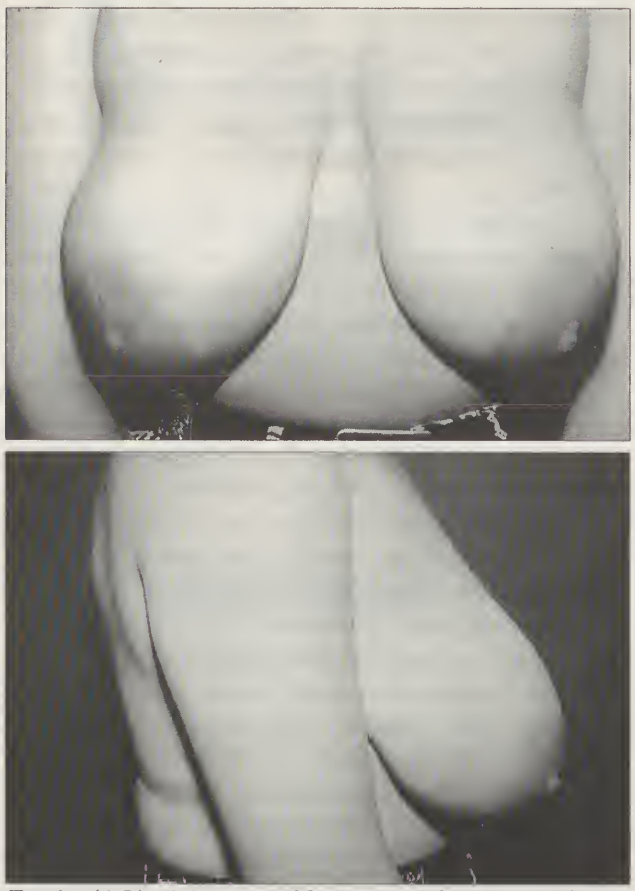


Fig 1. (A,B) A 34 year-old woman with moderate breast hypertrophy.

Discussion

In general, the inferior pedicle technique is applicable to breasts of many sizes and shapes. In large breasts where there is a globular-type shape with a narrow base, a good contour and size can be achieved [Fig 1]. In cases

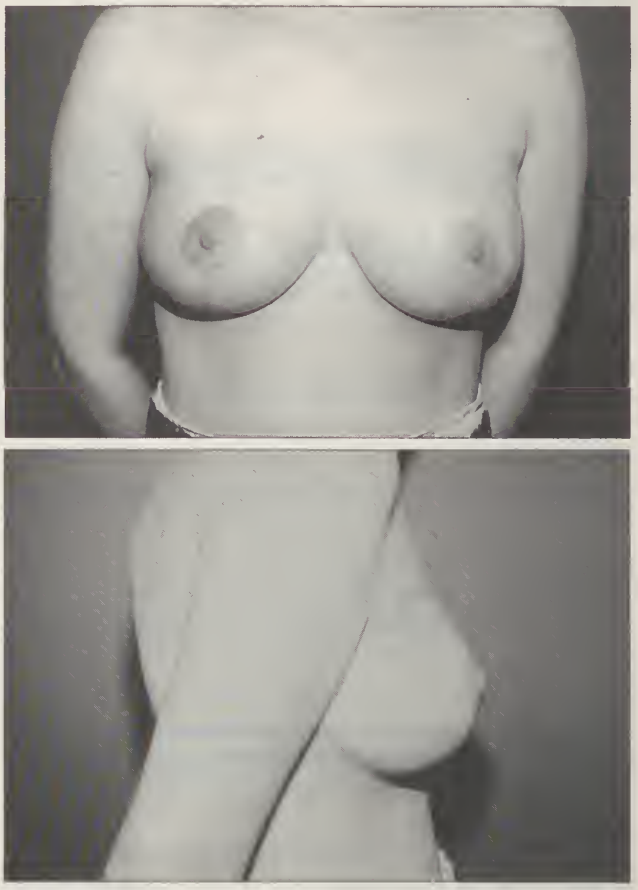


Fig 1. (C,D) 6 months following resection of 500 grams of tissue from each breast. (From Wallace, WH, Thompson, WOB, Smith, RA, Barraza, KR, Davidson, SF, and Thompson II, JT: Reduction Mammaplasty by Inferior Pedicle Technique. Annals of Plastic Surgery, Volume 40, No. 3, pp 235-240, March 1998.)



Fig 2. (A,B) A 24 year-old woman with moderate breast hypertrophy and asymmetry.

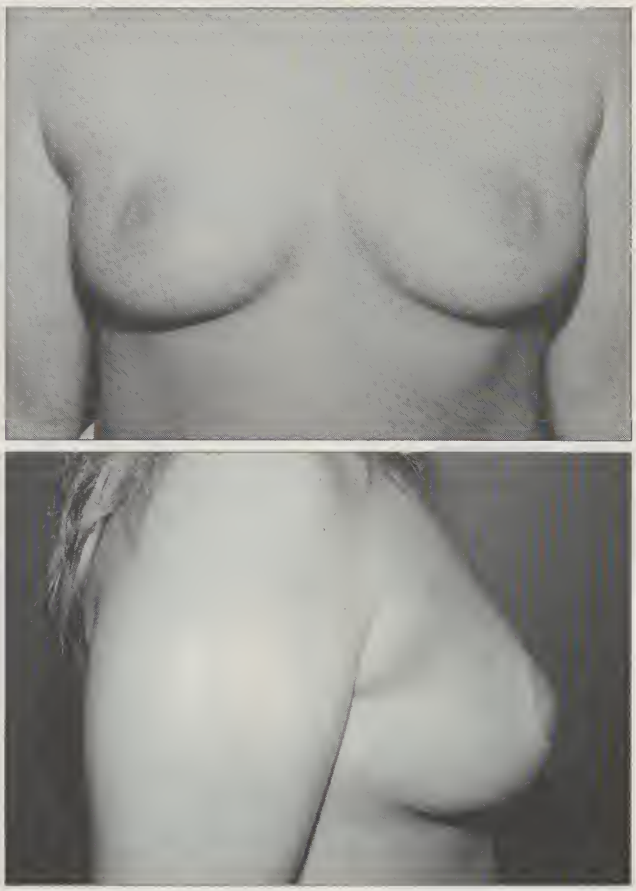


Fig 2. (C,D) 4 months following resection of 470 grams of tissue from the right breast and 670 grams of tissue from the left breast.

of asymmetry different amounts of breast tissue can be resected to gain symmetry [Fig 2]. Finally, in cases with large pendulous breasts which previously had been considered for free nipple graft, a reasonable size and shape can be accomplished with the inferior pedicle technique [Fig 3]. Since the incidence of epidermolysis and depigmentation of the nipples is significant when the free nipple graft technique is utilized, this complication can usually be avoided by using the inferior pedicle technique whenever possible. When a free nipple graft is needed, a technique using a partial inferior pedicle of breast tissue gives good shape and contour.

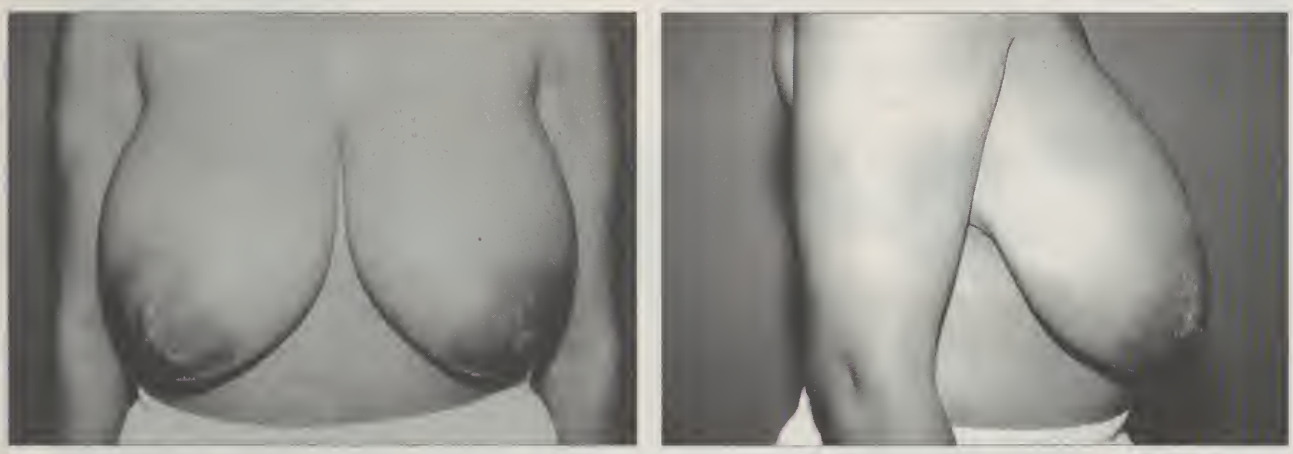


Fig 3. (A,B) A 29 year-old woman with marked breast hypertrophy.



Fig 3. (C,D) 4 months following resection of 860 grams of tissue from each breast. (From Wallace, WH, Thompson, WOB, Smith, RA, Barraza, KR, Davidson, SF, and Thompson II, JT: Reduction Mammaplasty by Inferior Pedicle Technique. Annals of Plastic Surgery, Volume 40, No. 3, pp 235-240, March 1998.)

Conclusion

Reduction mammaplasty by the inferior pedicle technique is highly effective in relieving symptoms caused by heavy breasts. This procedure may be performed in a timely manner with an acceptable rate of complications and can be safely and economically done as an outpatient or 23-hour observation. It is appropriate for most breasts regardless of size or shape, and it has reproducible results with preservation of nipple sensation in most patients. The resultant scars, when kept to a minimum and allowed to follow the breast mound contour, are acceptable to patients.

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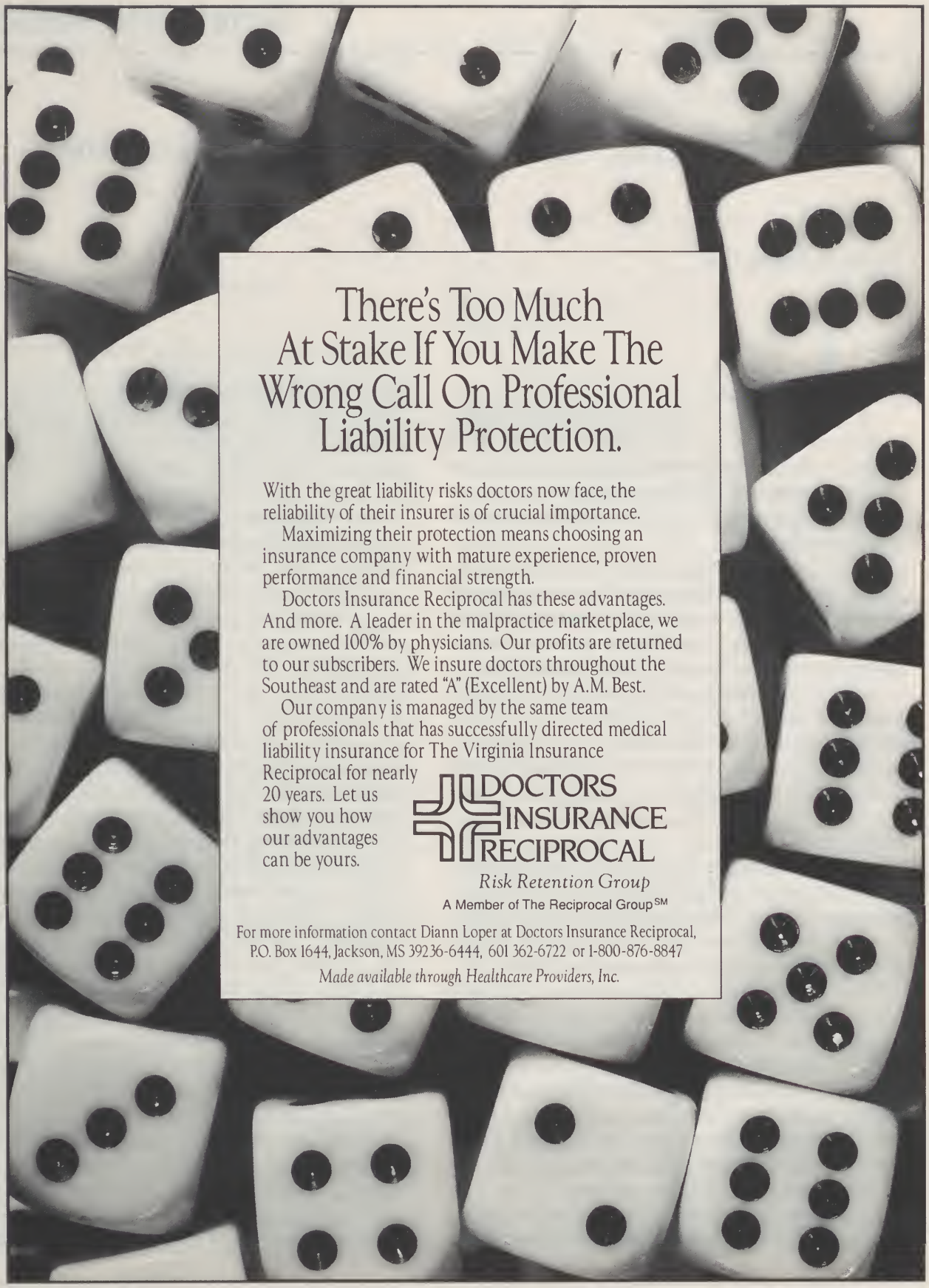
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Colorectal Cancer- Chemoprevention

Walter T. Boone, M.D.

ABSTRACT

Colorectal cancer is the second leading cause of death from cancer in The United States. During the last fifteen years, emphasis has been placed on identification of high risk patients and families and outline of appropriate surveillance regimens for normal and high risk patients for colorectal cancer.

Parallel to this effort, abundant clinical data has been accumulated that chemoprevention of colorectal cancer with nonsteroidals and aspirin may be possible. Interruption of prostaglandin metabolism appears to be one of the mechanisms of action but not the only therapeutic arm.

Currently, sulindac, aspirin, calcium and selenium supplementation are attractive recommendations to at risk patients awaiting results of clinical trials. Other agents in development add excitement to the concept of colorectal cancer chemoprevention.

INTRODUCTION

Colorectal cancer is the second leading cause of death from cancer in the United States. In 1997 it was estimated that 150,000 new cases would be diagnosed and about 60,000 patients would die of this disease. In Mississippi, colorectal cancer deaths numbered 6,000 in 1997. [1] In the United States, an individual has about a 5% chance of developing colon cancer during lifetime.[2] Differences in dietary habits and lifestyles among populations in different geographic locations have been associated with an altered risk for developing colorectal cancer. Although several studies have shown that persons on a high fat diet with a sedentary lifestyle have an increased risk for developing cancer of the large intestine, the etiology of colorectal cancer is not clearly understood.[3]

Abundant clinical and histopathological data suggest that most, if not all, malignant colorectal cancers arise from pre-existing benign adenomas.[4] The change from a benign adenoma to a cancer is widely accepted to be an accumulation, not step wise, of mutations in specific genes controlling cell division, apoptosis, (programed cell death), and DNA repair. There is a wealth of evidence that dietary factors especially dietary fat and fiber influence the development of colorectal cancer. However, there has been little understanding of how these dietary factors and genetic factors interact.[5]

Since the report from Waddell and Lowery that sulindac reduced the size and number of rectal polyps in individuals with familial polyposis, attention has been directed to the interruption of the metabolism of arachidonic acid as a chemo preventive for colon cancer.[6] Figure 1 demonstrates the arachidonic acid cascade which generates a family of bioactive lipids that modulate diverse physiological and pathophysiological responses. Cyclooxygenase, the rate limiting enzyme in prostaglandin biosynthesis is inhibited by agents known collectively as NSAIDS. The best known of these are aspirin, indomethacin, ibuprofen, piroxicam, and sulindac.[7] There are two known isoforms of cyclooxygenase, Cox-I and Cox-II. Cox-I and II is irreversibly inhibited by ASA and reversibly inhibited by indomethacin, ibuprofen, piroxicam, and sulindac. Cox-I is expressed in most tissues and has a role in tissue homeostasis. Cox-II is induced by a variety of cytokines, mitogens and growth factors and cannot be detected in most tissues under physiological conditions. It is, however, up regulated in murine intestinal tumors, in 40% of human colo-rectal adenomas, and 85% of colorectal cancers, which is circumstantial evidence that Cox-II activity may drive intestinal tumorigenesis. Consequently, Cox-II activity is an extremely attractive target for chemoprevention. It is not surprising that a class of

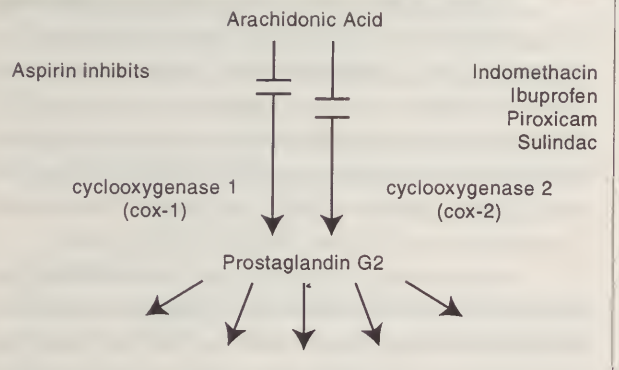


Figure 1. Arachidonic Acid Cascade

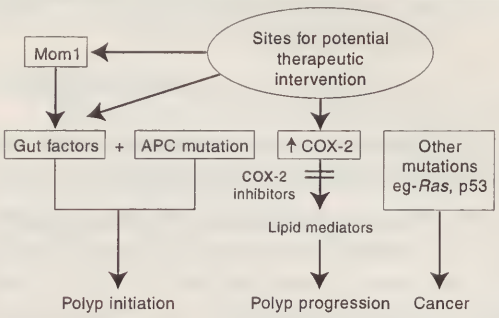


Figure 2. Mom1 and COX-2–roles in colorectal carcinogenesis?

Adapted from Watson, AJ.M, DuBuis R.N. Lipid Metabolism and APC: Implications for Colorectal Cancer prevention. Lancet 1997; 349:444-445.

nonsteroidals that are highly selective for Cox-II over Cox-I are chemo preventive in murine models of intestinal tumorigenesis.[8] The advantage of these Cox-II selective nonsteroidals is that they cause relatively little gastrointestinal toxicity. This is distinct from the widely used traditional nonsteroidals such as aspirin and sulindac sulphide, which also inhibit Cox-I and, in so doing, produce renal and gastrointestinal toxicity.[9]

Recent studies on the function of the adenomatous polyposis coli (APC) gene and how it's effects are modified by phospholipase A2 and cyclooxygenase, two enzymes involved in lipid metabolism, have begun to shed light on the interactions between genetics, dietary fat, and fiber (Figure 2). Mutations of APC gene cause familial adenomatous polyposis. APC gene also undergos mutations in up to 50% of sporadic colorectal cancers and is commonly mutated early in the transition from normal epithelium to an adenoma. The APC gene has been proposed to act as a "gate keeper"[5], ensuring that cell division is balanced by cell death. Mutations in colonic epithelium affecting genes involved in carcinogenesis presumably occur frequently, but are of little consequence because these mutant cells are removed by cell death. For a cell to become malignant the apoptysis mechanism must first be relaxed. In figure II, it is proposed that an APC mutation requires an external factor such as digestive secretions, dietary components, or intestinal flora before colonic tumors will develop.

Recently, the secretory phospholipase A2 gene has been proposed as a candidate for the MOM-1 locus. This enzyme is involved in the production of arachidonic acid, a substrate for the production of prostaglandins and leukotrienes. How this enzyme modifies tumor susceptibility is unknown, but it is interesting that it is secreted by the Paneth cells into the intestinal lumen where it could digest dietary fats or where it's bacterial side effects could alter bacterial flora.[10]

With that background, it is appropriate to examine the existing information in human and animal studies of colorectal cancer prevention.

SULINDAC (Clinoril)

The original observation that NSAIDs may affect the growth of colon neoplasms in humans was made by Waddell and Lowery.[6] They noted that treatment of desmoid tumors in patients with Gardner Syndrome with sulindac led to an impressive reduction and even complete resolution of colonic adenomas. None of these patients developed colon cancer during the treatment period, which lasted more than six years. When sulindac treatment was discontinued, colon adenomas recurred in three patients but retreatment of these patients led to their disappearance. Since that time there have been several randomized controlled trials of sulindac treatment for polyps in familial adenomatous polyposis patients. Varying doses of sulindac were used (100 mgs. TID, 150 mgs. BID, 200 mgs. BID), but all studies demonstrated a significant reduction in number and diameter of polyps.[11-14] Recently, a 50% decrease in polyp diameter in sporadic adenomas has been observed after a year's treatment with sulindac at 150 mgs. BID and 150 mgs. daily.[15]

We know that sulindac blocks prostaglandin synthetase by inhibition of cyclooxygenase I and II. However, there is a growing body of evidence that it's chemoprevention effects may be related to other aspects rather than interruption of prostaglandin metabolics.

Two compounds are produced in the metabolism of sulindac. It is reduced to sulindac sulphide which inhibits cyclooxygenase I and II. (Fig. #3) By oxidation, it is secreted in the bile as sulindac sulfone (FGN-I) which may attain a 20-40 fold increase in concentration as it bathes the colonic epithelial cells. Sulindac sulfone does not affect prostaglandin synthetase but does induce pro-

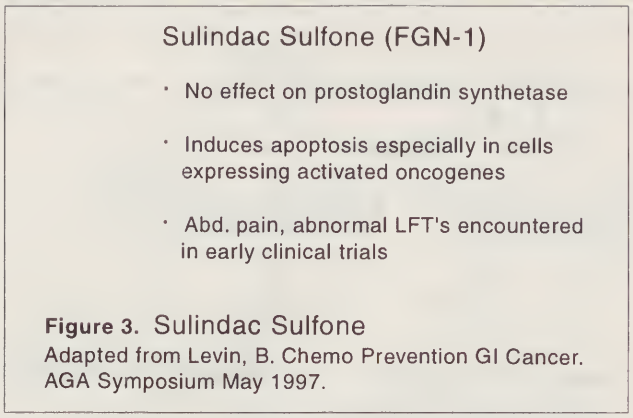


Figure 3. Sulindac Sulfone
Adapted from Levin, B. Chemo Prevention GI Cancer. AGA Symposium May 1997.

gram cell death especially in cells expressing activated Ras. oncogenes. Indeed, sulindac sulfone has none of the renal side effects of it's mother compound, but abdominal pain and abnormal liver function tests have been encountered in early clinical trials. In nine of eleven familial adenomatous polyposis patients treated with sulindac sulfone for six months, there was endoscopic evidence of flattening and size diminution in small 5.0 - 6.0 mm. polyps. Although these observations are limited to small sample numbers, they provide direct evidence of polyp regression following drug treatment.[16]

ASPIRIN

The first epidemiological study suggesting that aspirin reduces the risk of colon cancer was reported in 1988 by Australian researchers. [17] This retrospective study concluded that aspirin users had a 40% lower risk of colon cancer than nonusers. Thun and colleagues [18], in a large cancer prevention study involving 662,424 adults, observed a 40% lower risk of fatal colon cancer among people using aspirin sixteen or more times a month for at least one year compared with those who did not use aspirin. The enormous size of this study, it's prospective design, and the fact that risks decreased with both the frequency and duration of aspirin use, strongly support the evidence of beneficial effects of aspirin. More recently, a prospective study of 47,000 male professionals concluded that aspirin intake is associated with a strong dose dependent reduction in risks for both colorectal cancer and adenomatous polyps.[19] One cohort study in the elderly found no association between aspirin and the incidence of colorectal cancer.[20] An interventional trial using alternate day aspirin found no reduction in the number of cases of colorectal cancer during the first six years of followup.[21] This could mean that an effect on colorectal cancer requires more than six years of regular aspirin consumption or a higher dose of aspirin, or that an association does not exist.

Conclusions that may be warranted by colation of these studies are as follows: (1) aspirin decreases the incidence of colorectal cancer by 40%; (2) duration of aspirin ingestion may be crucial (at least 10 years); (3) the dose and frequency of aspirin required in colorectal cancer chemoprevention is unclear. There are five current human studies ongoing that should resolve the questions about dose and frequency of ingestion.

Substantial evidence suggests that aspirin acetylates proteins which inhibit the formation of prostaglandins from arachidonic acid as well as inhibiting phospholipase C. However, it is not clear that the suggested chemoprevention of colorectal cancer is related to these findings.

ANTIOXIDANT VITAMINS

Most of the epidemiological studies have focused on the dietary content of several micronutrients, and increased ingestion of fruits and vegetables has been associated with a decreased risk of cancer. Focus on B-keratin, vitamin C, and vitamin E identified the antioxidant functions of these vitamins which are capable of scavenging free radicals and protecting the cell membrane lipids from the harmful effects of oxidative degradation.[22] However, there have been no published clinical trials demonstrating chemo preventive efficacy in colorectal cancer from these compounds.

FOLIC ACID

Clinical observation from several different groups point to an association between diminished folate status assessed by either dietary intake or measurement of blood levels and enhanced risk of colorectal adenomas or cancer.[23] Giovannucci analyzed a prospective population of 25,474 patients with colonic adenoma and demonstrated a 30% decrease in those patients with adequate folate status and a similar study in 47,931 patients with colon cancer demonstrated a significant reduction in recurrence in patients with adequate folate status. In both studies, the association of moderate to high alcohol intake greatly increased the neoplastic risk of a low folate diet.[24,25] Two interventional studies with folate supplementation of 1 mgm/day and 10 mgm/day have been suggestive of chemoprevention but were inconclusive.[26,27]

The mechanism by which diminished folate status enhances carcinogenesis is speculative. There are many potential mechanisms by which folate deficiency may lead to cancer-induction of DNA, hypo-methylation, increased chromosome fragility and/or diminished DNA repair, diminution in natural killer cell surveillance, and

facilitation of tumorgenic virus metabolism.[23]

A rapidly growing body of clinical studies suggests that folate status can modulate the process of carcinogenesis. Data supporting this effect seems to be strongest in the area of colorectal carcinoma. At present, folic acid supplementation as a chemo preventive for colon cancer raises more questions than answers.

CALCIUM

For a number of years, epidemiological and case control studies have evaluated the inverse relationship between dietary calcium and risks of colon cancer. Not all studies confirm such a relationship. A nineteen year prospective study in American men between the ages of 14 and 55 showed a reduction in colon cancer, justifying further exploration of calcium as a colorectal chemo preventive agent.[28] A large scale population based study, soon to be reported, demonstrates a decrease in adenoma formation in previous colon adenoma patients who took 1200 mgs. of calcium supplementation daily.[29]

The mode of action of calcium chemoprevention is thought to be its luminal activity with interactional binding to bile salts as well as its ability to suppress colonic epithelial proliferation.[30]

SELENIUM

Selenium is a naturally occurring element found in mushrooms and garlic. Selenium supplementation has recently been reported to cause significantly reduced incidence of colon, lung and prostate cancer.[31] In vitro, selenium induces program cell death in the HT-29 colon cancer cell model and decreases formation of aberrant crepts (putative precursor lesion of colon cancer) in carcinogen induced colon cancer.[32]

Clark presented a double blind, randomized placebo controlled cancer prevention trial with 200 micrograms of selenium daily. Of the 113 patients with new adenomas diagnosed during the first ten years of the trial, 45 were in the selenium group and 68 in the placebo group. Colorectal cancer was also significantly lower in the treatment group with eight cases compared to nineteen cases in the placebo group.[32]

The mechanism of chemoprevention of selenium supplementation is unknown.

Newer agents receiving attention in chemo prevention of colon cancer are the green tea derivatives (the epicatechin, curcumin, (turmeric), ursodeoxycholic acid, isoflavones, and Oltipraz, an antischistosomal drug.) All of these agents have shown considerable activity in chemoprevention in the rat colon model. These agents are about to be or are currently in clinical trials for chemoprevention of colon cancer.

CONCLUSION

With the array of compounds that lie at our disposal for chemoprevention of colorectal cancer, we should continue to emphasize preventive strategies such as reducing fat intake and increasing consumption of fiber, vegetables and fruits. Because of the potential gastrointestinal, renal, central nervous system side effects of nonsteroidals, there would be universal reluctance to prescribe these to all patients, particularly the elderly, for chemo prevention of colon cancer. Potential candidates for chemoprevention trials with sulindac would be those patients with a mutated adenomatous polyposis coli gene who do not yet have colorectal polyposis, those with hereditary non-polyposis colorectal cancer, and those with sporadic colorectal adenomas.[34] Sulindac reduces the number and size of colorectal adenomas in patients with familial adenomatous polyposis, but is unlikely to replace colectomy as a primary therapy in this group of patients.[34] Although the data is not clear, sulindac may be of potential benefit in patients with familial adenomatous polyposis who have duodenal adenomas.

We anxiously await a new class of NSAIDs being developed by pharmaceutical companies world wide. These drugs are highly selective inhibitors of Cox-II having little or no effect on Cox-I activity. In recent studies, these drugs have been shown to have fewer side effects such as gastritis and ulcer disease, presumably due to their lack of Cox-I inhibitions and have excellent potential for chemoprevention.[35]

In addition to outlining stool occult blood tests and endoscopic surveillance for polyp and colorectal cancer patients and their families, it is reasonable to consider chemoprevention.

So what should we recommend to our patients with a normal risk factor or a high risk factor for colorectal cancer and their families? Since the data implies that aspirin ingestion may require years to show effectiveness, sulindac, if tolerated, may be the choice for those patients in high risk categories for developing colorectal ancer.

There is also data available allowing the physician to suggest calcium carbonate (1200 mgs. daily) and selenium (20 mcgs. daily) until further clinical trials are completed. Folic acid supplementation at normal and mega doses is suggestive of benefit but not proven.

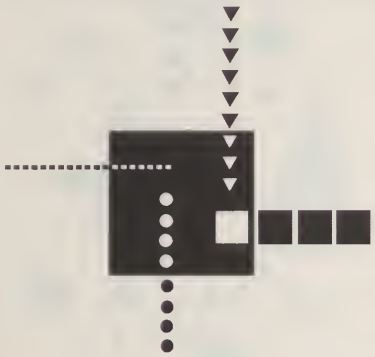
The issue with colorectal cancer chemoprevention for the future may not be the cost or side effects of the medication but the long term compliance of the patient.

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Coding Concepts

Q. When a patient is admitted to a psychiatric partial hospitalization program, please advise the appropriate code(s) used to report physician services and any required documentation guidelines.

A. According to the guidelines under the subheading Hospital Inpatient Services, CPT states "The following codes are used to report evaluation and management services provided to hospital inpatients. Hospital inpatient services include those services provided to a patient in a "partial hospital" setting."

This statement is repeated in the guidelines under the subsection Psychiatry with an explanation of what the services entail. Therefore, the appropriate code selection would be based on the level of history, examination, and decision making required to select codes 99221 - 99223. These services include writing hospital orders, exchanges with or supervision of nursing or ancillary personnel, reviewing laboratory or other diagnostic studies, reviewing activity therapy reports, and any treatment requests.

Q. I work in a rehabilitation unit. We often treat patients who have prolonged bed rest resulting in muscle weakness or because of the surgical procedure need to be rehabilitated because of weak muscles. What diagnoses should we use to describe these circumstances?

A. There are several applicable diagnoses that could apply to this situation. You may wish to review the following to see which would be applicable based on the patient's condition and circumstances

335.21 Progressive muscular atrophy
335.29 Other muscle atrophy
799.3 Debility unspecified
958.6 Volkmann's ischemic contracture
(E.g., Post traumatic muscle contracture)

You may wish to consider using V codes as secondary diagnoses to describe or identify events resulting in muscle weakness. I suggest you review the following V codes for appropriate applications.

V15 Other personal history presenting hazards to health.
V43 Organs or tissue replaced by other means
V45 Other Postsurgical states
V49 Problems with limbs and other problems
V57 Care involving use of rehabilitation procedures

CODING TIP

Before selecting a code, be sure that the documentation supports the level of service billed and that information for the diagnosis is complete. List any conditions or factors that affect the patient's care or conditions being treated for that visit.

Do you have a question you would like answered in the Journal? Send your inquires to Wanda L. Adams, CPC, 3280 Lupine Drive, Arnold, MO 63010. Please include your name and phone number should additional information be required.

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ABOUT THE AUTHOR

Wanda L. Adams, CPC, is a healthcare consultant and published author. She is founder and past president of the St. Louis Chapter of the AAPC. She currently serves on the National Advisory Board of the AAPC and the Editorial Panel of Code Facts, a Medicode publication.



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Michael H. Carter, Jr., M.D.

The President's Page

"It Takes a Doctor"

When the Democrats lost control of the Congress in 1953, House Speaker Sam Rayburn lost his position of power. In a farewell address, the Speaker encouraged his fellow Democrats to overcome party prejudices and welcome President Eisenhower who the Speaker believed to be ill-prepared for the job ahead. Speaking about the popular war hero Rayburn said, "Remember, any jackass can kick over the barn, but it takes a carpenter to build one."

I recount this story because it is precisely why I believe that Physicians Care Insurance Company (PCIC) is so important to the future of Mississippi medicine. All too often, we have seen quality health care take a back seat to cost at the hands of non-physicians. The future of health care in this state will depend on how well and how quickly health care companies can offer employers and employees not only cost efficient care but, at the same time, truly high quality medical care.

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I agree with Speaker Rayburn. Any jackass can kick over the barn. But it takes a doctor-driven company to "build" a managed care plan that truly puts quality patient care above all. Physicians in Mississippi have a unique opportunity to step on the bandwagon and invest in our profession by "building" an insurance company that will preserve the principles in which we believe. We have an opportunity to invest in a future that will protect privacy and the physician-patient relationship.

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>
> In the 1960's, when a peer review organization was needed, the Mississippi Foundation For Medical Care was formed by members of MSMA.
>
> In the mid 1970's, when premiums for medical liability insurance were skyrocketing and insurors were threatening to leave the medical malpractice market altogether, MSMA leaders established Mississippi Medical Fraternal and Educational Society (now MACM- Medical Assurance Company of Mississippi).

In other areas of the US, managed care schemes of various forms have severely assailed the sacrosanct province of patients and doctors. We all are aware of great negative changes which have led to dispirited feelings and major upheavals among physicians, leading in many cases to wasteful career changes, relocations, and specialty frictions.

Hospitals and hospital systems have their own concerns, which coincide with ours to a greater or lesser extent, and we have an interest in our hospitals' fiscal viability-indeed, health. We should work cooperatively with our hospitals, but we shirk our professional duty if we sit back and expect hospitals to safeguard the important elements of the proper relationship between doctors and patients.

Financing of routine, inexpensive, as well as very expensive, extraordinary health care services and procedures has moved progressively from an integral part of the transaction between doctors and patients to a responsibility assumed by corporations, government entities, and other employers---and the financial risk transferred in many, or most, cases to insurance entities---thereby interjecting these elements into the area previously the exclusive province of doctors and patients. These "payers" understandably and necessarily are motivated to control expenditures but their methods in these efforts many times have been clumsy, overconcerned with macro-scale financial goals, insensitive to individual situations, and generally destructive to good healthcare.

These elements are not going away. The sheer magnitude of cost of healthcare precludes "going back to the way it used to be" in healthcare finance. This change in the financial aspect of the "doctor patient relationship" jeopardizes the integrity of this crucial relationship, subjecting it to the capricious effects of ill-conceived notions about how to control costs.

This over lengthy preamble, yet another recapitulation of the by now obvious story of how we have arrived at this point, simply is to lead up to saying that we have at hand a sound mechanism to reclaim the primacy of the doctor-patient relationship.

Virtually all physicians entered this profession for altruistic and unassailable reasons, which we know very well. Practicing medicine has given all of us wonderful rewards, only one of which is a good financial livelihood for ourselves and our families. Among the more important rewards of our professional activities are the mutual respect among our colleagues and also positive regard from our patients and the public at large. This respect which flows to each of us has not been earned individually but devolves from the work of many, many physicians---both our contemporaries and physicians of previous generations.

Recently I was visiting with a thoughtful friend, who is an independent health insurance agent; he was asking me about our Physicians Care Insurance Company, which I have described publicly in a couple of recent presentations to local civic clubs. He expressed surprise that---at a time when other insurance companies claim to be losing money and to be considering leaving the health insurance area---we physicians are striving to enter this arena. He pointed out the difficulties which insurance companies have encountered in controlling their costs (and maintaining a profit margin sufficient for stockholders, etc.---not to mention the often obscene incomes of the upper-level company executives). I explained to him that, while we recognize that our company must operate in the black (i.e., profitably), we will not be

motivated by an intention to maximize profits for this company and its stockholders; therefore we should be able to price our insurance products at competitive premium rates. Additionally, MSMA members have long been involved in competent peer review activities---so that we already are prepared to carry out our own, very important and necessary UR function.

Though virtually all physicians in the United States have been impacted to some extent by the intrusions of "managed care," at present there still is relatively low penetration into the Mississippi market by the most objectionable forms.

Our company will be owned by Mississippi physicians, its Board will be elected by and made up of Mississippi physicians, its procedures and policies will be established by Mississippi physicians with primary emphasis on what is best for our patients, and therefore the company and its methods of operating will make sense to us physicians and our patients. Once established, these operational policies will set the standard for other companies attempting to compete in our state; patients and physicians no longer will have to be impeded by irrational obstacles to timely and appropriate health care; "gag" provisions in physicians' contracts, unreasonable "hold harmless" contractual clauses, arbitrary exclusion of physicians from panels---all these will be distant memories.

Expert insurance consultants have led us to the conclusion that adequate initial capitalization for PCIC is $15 million. I believe that we can raise this much and more from MSMA members at a minimum per member investment of $15,000. Though this amount of money is not small change, a mechanism for a convenient loan for this amount is available to every member, with terms that are manageable for virtually any one of us.

In short, there is a real need for this project, and we are well prepared to see it through to successful operation. This is our profession.... This is our profession. If we don't take care of it, who will? This is our time.

-Michael H. Carter, Jr., M.D.
MSMA President

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Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXIX, NUMBER 9
SEPTEMBER 1998

Ground Rules

Rather than especially steep, the learning curve has been abruptly abbreviated—appointed associate editor in late May and given an initial deadline of August 1. Reminds me of the familiar old quip (paraphrased): Two months ago I couldn't spell "associate editor" and now I are one!

Rest assured that the import of this position has not been lost on me but be reminded that no resource will prove too trivial as inspiration for my editorial offerings—a drug rep's clever sales pitch, an intriguing SKY magazine blurb, a patient's insightful remarks, or, when faced with deadline desperation, random letters floating atop my bowl of alphabet soup.

An excellent example of serendipitous inspiration appeared ironically in today's WIZARD OF ID comic strip. The perennially-bungling knight-errant proclaimed, "Scientists have found the cause of rising healthcare costs." His vertically-challenged, ever-scowling king demanded, "What is it?" to which the knight retorted, "Sick patients."

Which story provides a perfect lead-in to my source for this issue's editorial. As unusual as a comic strip may seem for inspiration, a wacky Dave Barry column appearing in the Sunday paper's Southern Style section may seem even more far-fetched. However, a recent Barry masterpiece caught my attention with the headline DAVE DOESN'T WANT TO BE MEDICALLY INFORMED CONSUMER, PREFERS TO JUST STICK OUT TONGUE.

Dave went on to lament that he preferred "The Doctor Mortimer Cohn Health Care System" under which he had grown up and named for his childhood family doctor. Under this system, he explained, your mom took you to see Dr. Cohn who looked in your throat and then wrote out a prescription "in a Secret Medical Code that neither you nor the CIA could understand". You would never have dreamed of talking with Dr. Cohn about Zocor or any other topic because the longer you stayed in his office, the greater the danger that you might receive a "booster-shot".

Dave admitted that now instead of enjoying his favorite TV show, he lay wondering if he should be talking to his doctor about some drug prompted by the announcer's question, "Aren't there enough reasons in your life to talk to your doctor about Zocor?" Unlike now, when visits to his physician's office are limited to clear-cut medical symptoms "such as an arrow sticking out of my head", life as a patient was simpler as a child.

Situations often demand that we chuckle at them rather than despair. The medical profession in general and the current healthcare climate in particular seem to produce a bumper crop of such scenarios. However, whether tongue-in-cheek as in Dave Barry's complaints about being constantly nagged to death to talk to his doctor and reminded about how many grams of fat are in his chocolate ice cream or plaintive as in the concerns of my young paraplegic patient who lives alone and is gainfully employed on learning that his insurance company questioned the need for further hospitalization for treatment of cellulitis of the lower extremity secondary to infected decubiti of his foot, a sense of discontent with unnecessary red tape, excessive regulations, and arbitrary denials appears to be festering among today's "healthcare consumers".

And with patients' bill of rights legislation in the offing from both national parties, enlisting the active and vocal support of our patients in this effort will prove crucial. Historically, such battles fought solely by the medical profession have been viewed as self-serving, pocketbook issues by our legislators. Perhaps the cries of "Foul" and "Enough" from their "real" constituents in this election year will finally be heard and acknowledged. ***-Stanley Hartness, M.D.***
Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

A Chance to Guarantee Victims' Rights

This November we as citizens of the state of Mississippi will have the opportunity to vote to amend our constitution to give victims of crime certain rights. If passed, which it should be, Mississippi will become the 29th state in the nation to give constitutional protection to victims of violent crimes. This year the Governor and Legislature got together and unanimously passed a constitutional amendment giving victims constitutional protection which I think all of us in the field of medicine feel they should have. This basically allows victims to have the same rights as those accused of the crime. In order to do this, we must be assured that this amendment passes. Once it passes, if victims desire, they can notify the district attorney and exercise certain rights, such as the right to be notified of all proceedings, the right to restitution from criminals, the right to confer with the prosecutor on plea bargaining, the right to a transcript on court proceedings, the right to be present and make a statement at court proceedings, the right to confer and talk with the prosecuting attorney, the right to have victims' safety taken into consideration before allowing bond, the right of the victim to be separated from the defendant during the defendant's trial, the right to be notified of parole if the criminal is paroled, and the right to be notified when the defendant is released or escapes from jail. These rights only seem fair and I think it behooves all of us as physicians to see that those who have gone through this type of tragedy are protected.

-W. Briggs Hopson
President-Elect



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Mississippi Alliance delegates to the American Medical Associaton Alliance 1998 Convention in Chicago were: (front left to right) Nancy Bush, MSMA Alliance Advisor; Denita Horne, MSMA Alliance First Vice President; Jo Waites, representative to the MSMA Council on Public Information; Jeanne Morrison, AMA Alliance Health Promotion Committee Chair. (back left to right) Jean Hill, Past President, AMA Alliance and Special AMA Alliance Adivisor to MSMA Alliance; Cathy Gersh, MSMA Alliance President; Merrell Rogers, SMA Auxiliary Vice President for Doctors' Day; Mary Helen Schaeffer, MSMA Alliance President-Elect; and Barbara Shelton, Alliance Staff Executive.

Jeanne Morrison of Hattiesburg has been appointed to the AMA Alliance Board for 1998-99. She will chair the Health Promotion Committee. During the previous two years, she served on this Board as a member of the Legislation Committee. Jeanne is a Past President of the MSMA Alliance and has served in numerous positions on its Board.

MSMA Alliance Wins HAP Award Again



Denita Horne, MSMA Alliance First Vice President, Mississippi Alliance delegate to the American Medical Associaton Alliance 1998 Convention in Chicago accepts the Health Awareness Promotion Award from AMA President Percy Wootton.

The Mississippi State Medical Association Alliance is well known for its participation in the AMA Alliance Health Awareness Promotion (HAP) project. During the past six years, the Alliance has won five times in various categories.

There were 53 entries for the 1998 program. Once again, South Mississippi-Jones County Medical Alliance was first in the Community Service category. Their winning project was entitled "CHECK OUT YOUR HEALTH: A HEALTH FAIR FOR HIGH SCHOOL."

In light of alarming state statistics on teen deaths, teen pregnancy, and infant mortality, the Alliance joined many local organizations and agencies in offering the first health fair to be held in any of the community's schools. More than 600 students received up-to-date, accurate information about teen health issues, as well as the opportunity to participate in health screenings to determine their risk for certain diseases and adverse conditions.

In addition to providing information and instruction on topics such as teen pregnancy, suicide, eating disorders, safety concerns, and violence prevention, The Alliance sponsored "Oh Baby, I'm Not Ready." This session, devoted to issues surrounding teen pregnancy, had students participating in the MYTHS AND CONSEQUENCES game show.

In 1996, the South Mississippi-Jones County Medical Alliance won first place in the Community Service category for their Women's Life Conference.

In Other News...

The North Central Medical Association Alliance won an award from the AMA Education and Research Foundation for the "Greatest Percentage Increase By County." Also, membership and recruitment and retention efforts are recognized annually by the AMA Alliance. Mississippi won for an over all 5% membership increase. The County Alliances with this membership increase were: Central, Homochitto Valley-Adams, Lee, Prairie-Oktibbeha and South Mississippi-Hattiesburg.

Information and Quality Healthcare Outpatient Diabetic Management Project

The Outpatient Diabetic Management Project undertaken in 1997 by Information and Quality Healthcare marked the first quality improvement project performed in the physician office setting. The importance of addressing diabetes in a Health Care Quality Improvement Project stems from its being the sixth leading cause of death and a major contributor to cardiovascular disease.

Total annual cost, direct and indirect, of diabetes in the state is estimated to exceed one billion dollars. Insulin dependent diabetics' risks for development and progression of the major complications of diabetes, such as retinopathy, nephropathy and neuropathy, are reduced by 50 to 70 percent under intensive treatment regimens.

The project affects five percent of Mississippi Medicare diabetic patients. Diabetes in Mississippi for the age group 65-74 rates among the highest in the nation.

The short-term objective is to assess current practice patterns in diabetes management in the outpatient setting. Long-term objective is to modify physician practice patterns and processes of care to decrease morbidity and mortality of diabetics.

Data were collected from 798 diabetic patients cared for by 30 physicians participating in the project over an 18-month time frame from July 1, 1995, through Dec. 31, 1996. Findings were presented to participating physicians in September 1997.

Methodology:

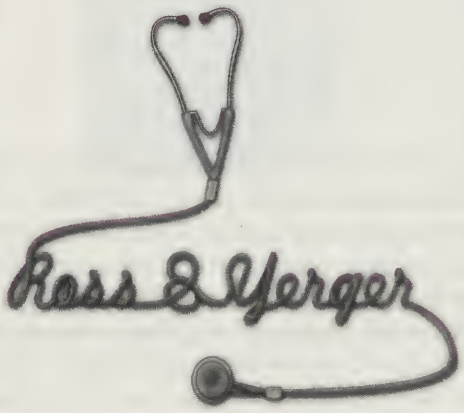
An I.Q.H. abstraction tool was utilized to collect the following frequencies: foot exams; urine microalbumin; microalbuminuria; prescribed ACE inhibitors; glucose monitoring methods and values; HbA1c/glycosylated hemoglobin and values; urine protein; lipids and fundoscopic eye examination. The study population represented Medicare patients with a diagnosis of diabetes who were treated by one of the 30 participating physicians. Physicians included family practice, internal medicine physicians, and endocrinologists.

Quality Indicators:

The percent of diabetics receiving the following care as recommended by the American Diabetes Association: dilated fundoscopic exam; foot exams; renal function monitoring; lipid profiles; ACE inhibitor therapy, HbA1c. Baseline data were presented to five participating clinics along with the ADA's current recommendations. Each physician was presented with an ADA wall template, ADA pocket guide, monofilament, and a project guide which included a suggested check sheet for charting.

Baseline study findings showed 7.1 percent of patients received foot exams, and 18.9 percent received HbA1c. A total of 22.9 percent of diabetic patients were referred for dilated fundoscopic eye exams annually. Findings reflected that 67.8 percent of the patients received urine protein screening (microalbumin and/or macroalbumin)with only 6.1 percent receiving microalbumin screening.

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Collaborators are currently in the intervention stage, which includes process changes, standardized check sheets for charting, and diabetic educational programs. Follow-up is scheduled to begin in April 1999.

I.Q.H. publishes a monthly newsletter with updates about the project. Informational articles from a variety of sources are also forwarded to collaborators.

Further information about this project can be obtained by contacting Trannie Murphy, RRA, CCS, who is serving as project manager.

TOBACCO SURVEY UNDERWAY

An overall response rate of 15 percent has so far been recorded in a survey to collect information on current tobacco prevention/cessation practices of Mississippi physicians and other health care practitioners. I.Q.H. and the State Department of Health released the survey which seeks to identify barriers making it difficult to provide counseling and support for patients. Information collected will help establish baselines to measure the success of future tobacco prevention projects such as those funded with tobacco settlement monies.

Groups targeted in the survey include physicians, nurses, nurse practitioners, dentists, dental hygienists, dieticians, and pharmacists.

-James S. McIlwain, M.D., I.Q.H. President

(The analyses upon which this article is based were performed under Contract Number 500-96-P510, entitled, "Utilization and Quality Control Peer Review Organization for the State of Mississippi," sponsored by the Health Care Financing Administration (HCFA), Dept. Of Health and Human Services. The content does not necessarily reflect the view or policies of the Dept. Of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government. The author assumes full responsibility for the accuracy and completeness of ideas presented. The article is a direct result of the Health Care Quality Improvement Program initiated by HCFA, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore, required no special funding on the part of this contractor. Ideas and contributions concerning experience in engaging with issues presented are welcomed.)

Annual Health Plan Process Begins

The Mississippi State Department of Health develops a State Health Plan each year under the authority of Section 41-7-173(s) and Section 41-7-185(g), Mississippi Code 1972 Annotated, as amended. The State Health Plan has three purposes: (1) to identify priority health needs in Mississippi;- (2) to recommend ways in which those needs can be met; and (3) to establish criteria and standards for health related activities which require Certificate of Need review. The Department includes public comment from the beginning of the development process through final adoption of the revised Plan.

The process begins each fall with a public forum generally held before the State Board of Health at the Board's October meeting. At this forum, any concerned individual has an opportunity to make suggestions regarding any aspect of the Plan or propose changes to Certificate of Need (CON) criteria and standards. Anyone unable to attend the forum may submit written comments by mail. Staff of the Division of Health Planning and Resource Development study the comments and develop recommendations for any needed changes in CON criteria and standards.

Each January, staff requests the Board of Health to approve an "intent to adopt" the proposed revisions and files the proposal with the Secretary of State. This action initiates a 30-day public comment period in accordance with Mississippi's Administrative Procedures Act.

The Department publishes proposed changes in a statewide newspaper, *The Clarion-Ledger*, mails a copy of all proposed changes to an established list of interested parties, and publishes the proposed changes in a monthly Department newsletter sent to more than 1,000 health care facilities, individuals, and organizations. The Department also provides the proposed changes to anyone who requests a copy.

Staff analyzes any comments received and incorporates them into proposed changes wherever possible. Staff presents final recommendations to the Board of Health at the April Board meeting each year. The Board approves or disapproves each proposed change and issues a "final adoption" of the revised Plan. The Department files the Plan as adopted with the Secretary of State.

Staff also obtains up to date statistical and general information from numerous departments of the MSDH, other state agencies, professional associations, and relevant organizations regarding every topic covered in the Plan. Staff compiles this information and produces a final Plan. Following approval by the Governor, the revised Plan becomes effective July 1 of each year.

New Members

ABUSHAER, MUHAMMAD B., Sardis. Born Damascus/Syria, October 24, 1964; MD Damacus University of Medicine, Syria, 1987; internal medicine residency, Mercy Hospital, Chicago, IL, 1991-1994; elected by North MS Medical Society.

BAROUDI, BASSAM R., Gulfport. Born Hama,Syria, May 18, 1959; MD University of Damascus Medical School, Damascus, Syria 1982; interned, Meridia Huron Hospital-Case Western Reserve University Affiliate, Cleveland, OH, 1988-89; internal medicine residency, Same, 1988-89 & Mt. Sinai Medical Center-Case Western Reserve University, Cleveland, OH, 1989-90; cardiology fellowship, same, 1990-93; elected by Coast Counties Medical Society.

BEEZLEY, ALVIA R., Hattiesburg. Born Austin, TX, February 13, 1958; MD Texas College of Osteopathic Medicine, Fort Worth, TX, 1993; interned and pediatric residency, University of South Alabama Medical Center, Mobile, AL, 19193-97; elected by South MS Medical Society.

BENNETT, RICHARD F., Bay St. Louis. Born Flint, MI, June 4, 1949; MD Michigan State University College of Osteopathic Medicine, East Lansing, MI, 1987; family medicine residency, Southeast University of the Health Sciences, Ft. Lauderdale, FL, 1987-88; family medicine residency, Mt Clemens General Hospital, Mt. Clemens, MI, 1989-90; elected by Coast Counties Medical Society.

BENSON, ROBERT W., Hattiesburg. Born May 16, 1951; MD Louisiana State University School of Medicine, New Orleans, LA, 1976; interned and dermatology residency, Charity Hospital of LA, 1976-80; elected by South MS Medical Society.

BREWERTON, CONWAY N., Ridgeland. Born Magrath, Alberta Canada, August 21, 1950; MD University of Alberta, 1977; interned one year, same, 1978-79; elected by Central Medical Society.

COLEMAN, ROBERT M., Laurel. Born Jackson, MS, October 5, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1992; family medicine residency, same, 1992-95; elected by South MS Medical Society.

CONDON, MARK A., Jackson. Born Portage, WI, July 27, 1966; MD Vanderbilt University School of Medicine, Nashville, TN, 1992; urology residency, University Medical Center, Jackson, MS, 1992-98; elected by Central Medical Society.

DENNIS, DAVID M., Oxford. Born Oxford, MS, May 16, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1995; pediatric residency, Vanderbilt University Medical Center, Children's Hospital, Nashville, TN, 1995-98; elected by North MS Medical Society.

GRAFF, JUSTIN C., Tupelo. Born Des Moines, IA, November 24, 1966; MD University of Iowa College of Medicine, Iowa City, IA, 1993; interned and neurology residency, same, 1993-97; fellowship, Mayo clinic, Rochester, MN, EMG & clinical neurophysiology, 1997-98; elected by Northeast MS Medical Society.

GRAY, LESLIE B., Meridian. Born Meridian, MS, December 9, 1965; MD Tulane University School of Medicine, New Orleans, LA, 1992; surgery residency, University of Tennessee Medical Center, Memphis, TN, 1992-97; vascular surgery fellowship, Same, 1997-98; elected by East MS Medical Society.

HARRIS, WILLIAM K., Jackson. Born Gulfport, MS, June 17, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1995; family medicine residency, same, 1995-98; elected by Central Medical Society.

HARRISON, J. SCOTT, Jackson. Born Union, MS, June 23, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1994; interned and internal medicine residency, same, 1994-98; elected by Central Medical Society.

KESSLER, VICTOR C., Starkville. Born Detroit, MI, May 24, 1945; MD Indiana University School of Medicine, Indianapolis, IN, 1971; internal medicine residency, Good Samaritan Hospital, Cincinnati, OH 1974-77; gastroenterology fellowship, same 1977-79; elected by Prairie Medicine Society.

KOE, FRANK G., Ridgeland. Bore Vicksburg, MS, November 29,1951; MD University of Missis-

sippi School of Medicine, Jackson, MS, 1976; elected by Central Medical Society.

LARTEVI, EDWARD K., Cleveland. Born Africa, March 18, 1948; MD Tulane University School of Medicine, New Orleans, LA, 1975; pediatric residency, same, 1976-78; anesthesiology residency, Bronx, NY; 1981-83; elected by Delta Medical Society.

MANNING, KAREN L., Hattiesburg. Born Butler, AL, July 24, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1995; family medicine residency, University Medical Center, Jackson, MS, 1995-98; elected by South MS Medical Society.

MCAULEY, ROBERT T., Tupelo. Born Birmingham, AL, August 24, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1993; general surgery residency, same, 1993-98; elected by Northeast MS Medical Society.

MARSHALL, ANDREA M. Jackson. Born Jackson, MS, February 25, 1964; MD University of Tennessee School of Medicine, Memphis, TN, 1994; interned and internal medicine residency, same, 1994-97; elected by Central Medical Society.

MONTES, MIGUEL A., Greenwood. Born Havana, Cuba, February 7, 1964; MD University of Texas Medical School, Houston, TX, 1992; pathology residency, Brigham & Women's Hospital Boston, MA, 1992-96; cytology fellowship, same, 1996-97and surgical pathology fellowship, Baylor, Houston, TX, 1997-98; elected by Delta Medical Society.

MOON, SCOTT D. M., McComb. Born Iowa, February 20, 1965; MD University of Hawaii, John A. Burns School of Medicine, Honolulu, HI, 1991; radiation oncology residency, University of Maryland, Baltimore, MD, 1993-96; fellowship in radiation oncology, same, 1996-97; elected by South Central Medical Society.

NICHOLS, KIMBERLY P., Jackson. Born Anniston, AL, December 27, 1964; MD University of Mississippi School of Medicine, Jackson, Ms, 1994; ob-gyn residency, University of Alabama Medical Center, Birmingham, AL, 1994-98; elected by Central Medical Society.

NIX, DAVID S., Meridian. Born Charlottesville, VA, June 17, 1956; MD University of Florida Medical School, Gainesville, FL, 1985; interned and internal medicine residency, Wilford Hall USAF Medical Center, Lackland AFB, TX, 1995-88; hematology & oncology fellowship, Stanford University, Stanford, CA, 1992-95; elected by East MS Medical Society.

OZMENT, DAVID D., Meridian. Born Mobile, AL, June 4, 1967; DO University of Health Sciences, Kansas City, MO, 1993: family medicine residency, University of Alabama-Birmingham/Selma, AL 1994-96; elected by East MS Medical Society.

PARK, MYUNG C., Clarksdale. Born Korea, October 9, 1941; MD Yonsei University School of Medicine, Seoul, Korea, 1962; surgery residency, St. Elizabeth Hospital, OH 1967-68; urology residency, Hamot, Hospital, Erie, PA, 1968-69; Roswell Park Memorial Institute & Children's Hospital & Millard Filmore Hospital, Buffalo, NY, 1969-72; elected by Clarksdale & Six Counties.

PARVIN, GREGORY A., Hattiesburg. Born Corinth, MS, August 28, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1995; pediatric residency, University of Arkansas for Medical Sciences, Little Rock, AR 1995-98; elected by South MS Medical Society.

RODRIGUEZ, RICARDO J., Gulfport. Born Ann Arbor, MI, October 16, 1964; MD Tulane University School of Medicine, New Orleans, LA, 1992; interned and orthopaedic residency, Tulane, New Orleans, LA, 1992-97; orthopaedic residency, Baylor College of Medicine, Houston, TX, 1997-98; elected by Coast Counties Medical Society.

RUSSELL, RICHARD L., Jackson. Born Oxford, MS, June 4, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1994; internal medicine, University Medical Center, Jackson, MS, 1994-97; elected by Central Medical Society.

SHERARD, REGINALD K., Ridgeland. Born Goldsboro, NC, November 30, 1955; MD Meharry Medical College, Nashville, TN, 1982; Brooke Army Medical Center, San Antonio, TX, 1984-86; elected by Central Medical Society.

SIEGEL, RANDALL S., Hattiesburg. Born Coshocton, OH, March 29, 1963; MD Ohio State University College of Medicine, Columbus, OH, 1990; interned and internal medicine residency, Same, 1990-93 & 94-96; elected by South MS Medical Society.

TRAXLER, JON G., Gulfport. Born Houston, TX, February 27, 1966; MD Louisiana State University Medical School, New Orleans, LA 1992; general surgery internship and otolaryngology residency, LSU Medical Center, 1992-98; elected by Coast Counties Medical Society.

TALBOT, PAUL J., Hattiesburg. Born Abington, PA, March 11, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1993; interned and plastic surgery residency, University Medical Center, Jackson, MS, 1993-98; elected by South MS Medical Society.

TENNIN, L.C., JR., Canton. Born Vance, MS, November 23, 1959; MD University of Minnesota, St. Paul, MN, 1980; internal medicine residency, University Medical Center, Jackson, MS, 1980-83; elected by Central Medical Society.

WINKLER, KENT D., Meridian. Born Elgin, IL, November 4, 1962; MD Chicago Medical School, North Chicago, IL, 1989; family medicine internship, Phoenix Bapt. Hosp., Phoenix, AZ, one year; internal medicine residency, Good Samaritan Hospital, Phoenix, AZ, 1991-94; cardiology fellowship, same, 1995-98; elected by East MS Medical Society.

YOUNG, RONALD S., Hattiesburg. Born Long Beach, CA, April 1, 1962; MD Medical College of Georgia, Augusta, GA, 1989; radiology residency, Baptist Hospital, Memphis, TN, 1990-94; vascular interventional radiology fellowship, University of Florida Medical Center, Gainesville, FL, 1994-95; elected by South MS Medical Society.

ZEINO, MERHAF, Greenville. Born Aleppo, September 26, 1957; MD Aleppo University, 1981; internal medicine residency, Cleveland, OH, 1991-94; nephrology fellowship, Emory Medical Center, Atlanta, GA, 19894-96; elected by Delta Medical Society.

ZSENITS, BALAZS, Yazoo City. Born Budapest, Hungary, September 4, 1967; MD Semmelweis University, Budapest, Hungary, 1991; internal medicine residency, Henry Ford Hospital, Detroit, MI, 1994-97; elected by Delta Medical Society.

Deaths:

BUCKLEY, RICHARD E., Biloxi. Born June 9, 1936; MD University of Mississippi School of Medicine, Jackson, MS, 1961; died July 21, 1998, age 62.

WINSTEAD, WILLIAM B., Pascagoula. Born March 7, 1922; MD University of Mississippi School of Medicine, Jackson, 1958; died July 24, 1998, age 76.

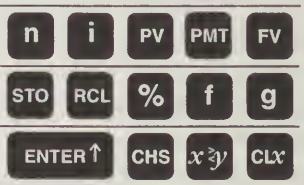
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Michael J. Borne, M.D., Assistant Clinical Professor in the Department of Ophthalmology at the University of Mississippi School of Medicine in Jackson recently published a chapter titled "Retinal Detachment" in *Ophthalmology Secrets*. The book provides answers to some of the most frequently asked questions in the field of ophthalmology. He also has a research article appearing in an upcoming edition of the peer reviewed journal, *Annals of Ophthalmology*. The article is titled "Factors Associated with Rhegmatogenous Retinal Detachment." Dr. Borne is an ophthalmologist specializing in diseases and surgery of the retina and vitreous. He is in private practice with Mississippi Retina Associates. P.A. in Jackson.

C. Ron Cannon, M.D. served on the Editorial Review Board for the *Journal of Otolaryngology-Head & Neck Surgery.* Dr. Cannon was also nominated for Chair-Elect of the Board of Governors for the American Academy Of Otolaryngology-Head & Neck Surgery.

Kevin H. Bond, M.D., of Tupelo, MS, recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at North Mississippi Medical Center. **Jesse L. Wofford, M.D.,** FACS, of Jackson, recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at G. V. "Sonny" Montgomery VA Medical Center. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons. Dr. Bond and Dr. Wofford are among a national network of over 2,000 volunteer Cancer Liaison Physicians who provide leadership and support to the Approvals Program, and other Commission on Cancer activities. Dr. Bond and Dr. Wofford, who have a significant interest in the diagnosis and treatment of patients with malignant diseases, provide leadership to the cancer committee at their appointed institution(s) in order to maintain their Commission-approved cancer program, or assist them in seeking approval as a new program. Dr. Bond and Dr. Wofford also provide community leadership by volunteering at the division or unit level of the American Cancer Society. Established in 1922, the Commission on Cancer, which is composed of Fellows of the College and liaison members representing more than 37 other cancer-related organizations, has approved more than 1,480 cancer programs in institutions across the country. The Commission reviews each institution's cancer program for conformity to their established standards, and encourages participating hospitals to equip and staff themselves so that they are able to provide the best in the diagnosis and treatment of cancer.

J. E. Calloway, M.D., who has practiced medicine in Louisville for 50 years, recently saw his last patient as he closed his practice.

Larry D. Field, M.D. recently served as co-chairman for a course entitled "Arthroscopic Shoulder Surgery: Principles and Techniques" sponsored by the Arthroscopy Association of North America. While in Chicago Dr. Field also gave a presentation entitled "A Comparison of Arthroscopic and Open Shoulder Surgery for Anterior Instability."

Brown Robertson, M.D. has retired from Ear, Nose & Throat Physicians of North Mississippi, P.A. in Tupelo.

Claude A. Jackson, M.D. of Kosciusko was recently honored with a retirement reception given by Montfort Jones Memorial Hospital.

John R. Jackson, Jr. M.D. recently retired from pediatric service. Dr. Jackson practiced at the Pediatric Clinic, a service of Hattiesburg Clinic, for more than 30 years.

Jeff Clark, M.D. of Brookhaven was recently certified as a diplomate of the American Board of Urology.

John P. Fullenwider, M.D. has been elected to the Board of Directors for the Chamber of Commerce as the co-chairman for the 1998-1999 Leadership Lafayette Conference. Dr. Fullenwider is the Medical Director of JPB Pathology and

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

an active medical staff member of the Baptist Memorial Hospital-North Mississippi since 1991. During a three-year term on the Board of Directors, Dr. Fullenwider will be voting on policies and regulations for the Oxford-Lafayette Chamber of Commerce. Dr. Fullenwider has also been selected President of the Yoknapatapha Arts Council, which promotes arts throughout the Oxford and surrounding areas. He will serve a one year term coordinating and implementing plans of the Council.

John E. Moffitt, M.D. has been promoted to the rank of professor of pediatrics in the University of Mississippi School of Medicine. Dr. Moffitt took his medical studies at Mississippi College and earned his medical degree at the University of Mississippi, where he took internship and completed his residency in pediatrics. He also completed a fellowship at the University of Georgia.

Lewis W. Neese, M.D., a pulmonary and critical care medicine physician at Hattiesburg Clinic, has successfully completed the requirements for certification as a Diplomate in Critical Care Medicine by the American Board of Internal Medicine. Dr. Neese received his medical degree from the University of Alabama in Birmingham, Ala., and completed his residency in internal medicine and a fellowship at the Mayo Graduate School of Medicine, Mayo Clinic, Rochester, Minnesota. Dr. Neese is also board certified in pulmonary medicine and internal medicine.

Thomas M. Brill, M.D., board certified in family medicine, is now offering services at Madison County Medical Center's new Madison Clinic.

Ronald Young, M.D., has been selected as the recipient of North Mississippi Medical Center's 1998 Golden Tongue Blade Award. He was nominated for the award by NMMC employees because of his outstanding contributions to customer service, teamwork, quality of care and leadership. The award is given annually to an NMMC physician. Dr. Young received the award at NMMC's Employee Recognition Banquet. Dr. Young is in private practice with Obstetrics-Gynecology Associates, P.A., Clinic for Women. A graduate of the University of Mississippi School of Medicine, Dr. Young joined the NMMC staff in 1996.

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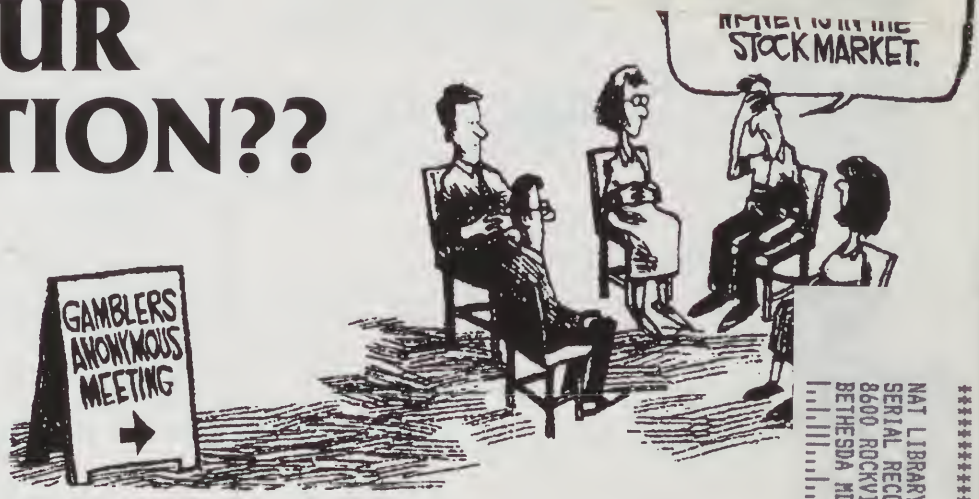
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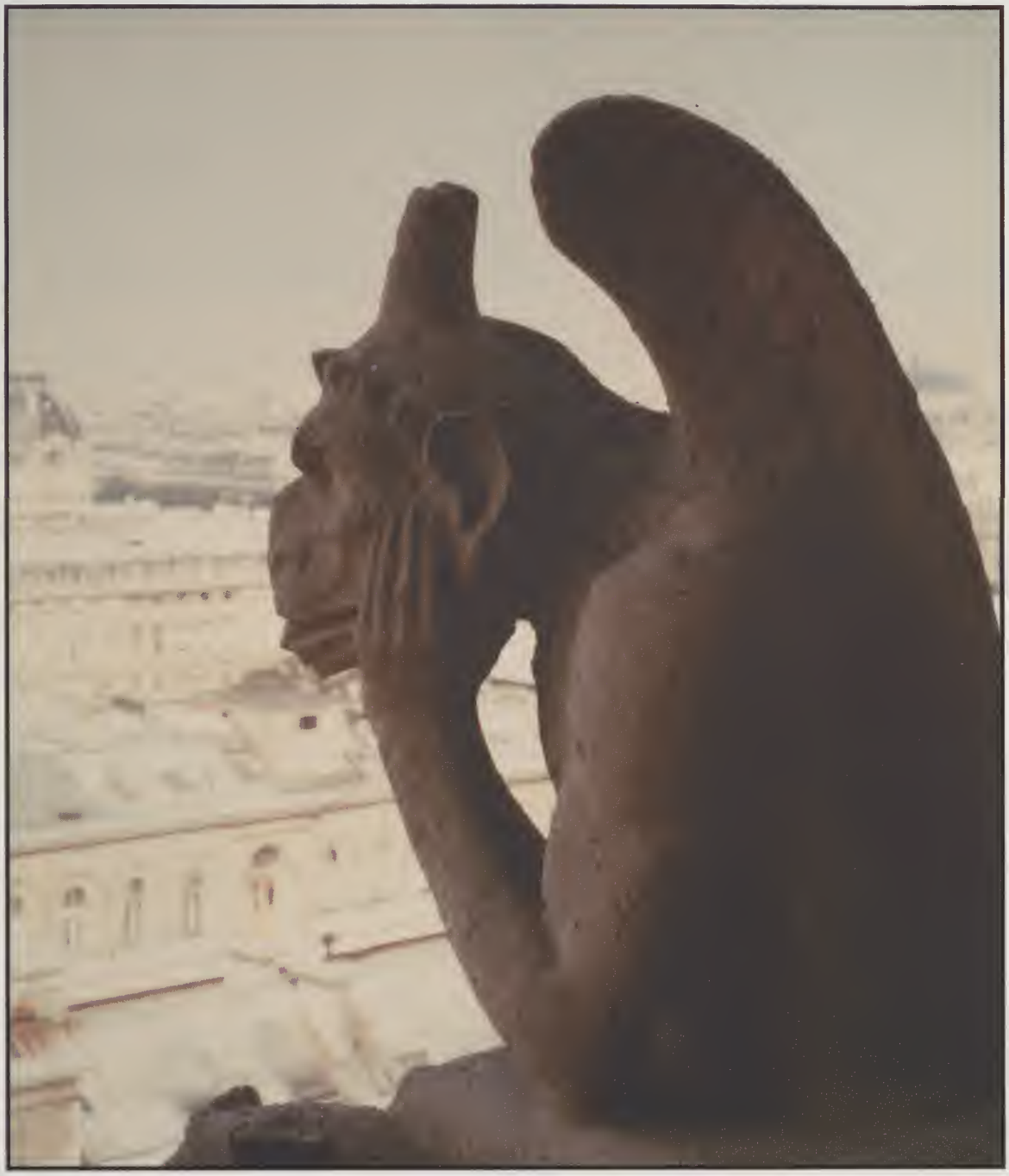
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The Anatomy Department of The University of Mississippi Medical Center A Short, Anecdotal History

Carroll R. Ball, Ph.D.

This is the first of a two-part article. Part 2 will appear in the November issue of the ***JOURNAL MSMA***—Ed.

INTRODUCTION

In the year 2003, the Anatomy Department of the University of Mississippi Medical Center will be 100 years old. There is a rich history here that needs to be remembered and recorded; in particular, the personalities who have lent direction as well as color to the Department.

Shelby Foote, addressing a meeting of the Mississippi Historical society, observed that academic and/or professional historians had trouble in the telling of a story because they "let facts get in the way of the truth". Since I am not a professional historian it seemed that truth in a narrative form would be the appropriate medium for the telling of the Mississippi anatomy story; certainly it would be more interesting, than the more traditional Genesis type of begetting which tends to be deadly dull. For documentary purposes, never the less, the obligatory begetting is to be found among the appendices.

For the early years of the department there has been a challenge in properly relating individuals to an administrative framework. At the turn of this century, the pattern of administrative structure and academic titles at the University of Mississippi was varied and inconsistent. The terms "school" and "department" were often used interchangeably. Frequently when a subject area had only one faculty member, the term "chair of..." was employed. In 1903, the official designation for the newly activated medical division was the "Department of Medicine and Surgery" with the administrative head to be the "Dean". The designation, "School of Medicine" first appears in the 1924-25 catalogue. A "Department of Anatomy" is first referred to in the catalogue of 1937-38, and a "Chairman of Anatomy" is first listed in the catalogue of 1941-42. Confusion and controversy over who and when an individual should be called "Chairman of Anatomy", or when a group of related courses should be called the "Department of Anatomy" has seemingly arisen from attempts to superimpose contemporary titles and administrative organization on the formative years of the institution. It simply does not convert.

Initially, when the term "anatomy" is used it is restrictive to gross anatomy, including a limited coverage of the gross nervous system. Histology was a course in the "Physiology and Histology Department"; Embryology was offered by the "Biology Department". The merging of these basic components into something comparable to the present day departmental consortium apparently takes place in the 1920's.

It is of interest that a number of the original faculty of the medical department were drawn from the general university ranks; for example Waller S. Leathers, M.D., who was to become the first Dean, had been "Professor" of a plethora of subjects at the University prior to 1903. This interdisciplinary overlapping continued for many years. Of greater interest is that for 30 of the fifty-plus Oxford years of the Anatomy Department the sole Professor of Anatomy (translate gross) was an MD. For 18 additional years there was an MD with the title of Professor of Anatomy in the "Department". For well

over half of the fifty-plus Oxford years, the Professor of Anatomy, or someone responsible for a related course such as histology, was or would become the Dean of the Medical Department/School.

I have been associated with the Department for almost one half of its existence. As pompous as that sounds, and indeed is, it is intended as a time frame of reference for what follows, much of which is by way of personal observation and/or personal communication. As I have sifted through the dust and mire of the available information concerning the Department's history, it occurs to me that I have been most fortunate within this frame; on the whole, it has been a good experience.



Fig 1. — Lyceum, University of Mississippi, Oxford. Photograph Circa 1860.

PART I - GERMINAL

The University of Mississippi, originally referred to as "the Seminary", was born "under the caul", so to speak. It was plagued by fiscal mismanagement and corruption even before it officially opened on Monday, November 6, 1848. The sole building was a pseudo - Greek temple, the original Lyceum (Fig. 1), in a bucolic setting, which had only 16 years earlier been Chickasaw Indian Land. Governor Albert G. Brown, responding to the legislative act of Feb. 24, 1844 which officially created "The University of Mississippi", duly appointed the original Board of Trustees; described as thirteen of the most eminent men in the state. [3] The trustees, in turn, had corresponded with the faculties of various colleges and universities in the United States and elsewhere to ensure that an appropriate educational program would be put into effect. This academic program, typical of the times, has been described as the classical mode, dealing as it did with such esoteric matters as mental and moral philosophy, rhetoric, logic, ancient and modern languages, pure and mixed mathematics, mineralology and the like.[5] As the price of cotton fluctuated, so it was reflected on campus, but it was the guns of war that spelled complete disruption to the halcyon days of the fledgling university.[3] The grim reconstruction years that followed the War necessitated a radical rethinking and restructuring of the mission and very existence of the institution. In 1870, then Chancellor Waddell proposed to the Board of Trustees that the original and current "close college" or close curriculum type of organization be changed into a University system consisting of three units: (1). Preparatory education, (2). Science, literature and the arts, and (3). Professional education consisting of two initial components, law and medicine. This proposal was accepted by the Board of Trustees and "the system was to be inaugurated as far as practicable by Autumn of 1871".[1,2,3,5]

At the same 1870 meeting of the Board a specific resolution regarding the proposed medical program was made to the effect that "this professional school will be organized and put into regular operation upon the plan in the University of Virginia which has proved to be so eminently successful".[5] By inference, someone on the Board must have had knowledge of the medical curriculum at the University of Virginia which had begun such classes in 1825, and for which Mr. Jefferson had recruited a young (age 26) Englishman named Robley Dunglison. The young doctor had an M.D. from the University of Erlangen, and additionally had attended lectures in London, Edinburg, and Paris. Dr. Dunglison's title at Virginia was Professor of Anatomy, Physiology, Surgery, Material Medical, Pharmacy and the History of Medicine.[16] An impressive range of obligations which in Oliver Wendell Holmes' words suggested "that he had not a chair but a whole settee".[16] We can reasonably conclude therefore, that with Virginia as a role model, the new medical school in Mississippi would be in the finest Anglo-European tradition; that is, that there was an emphasis on anatomy.

Glowing promises concerning medical training in ensuing catalogues to the contrary, "as far as practicable" lasted for thirty years,[2] and it was not until 1903 that a medical department (Department of Medicine and Surgery, as it was termed), was finally activated.[3] Action at this time due most probably to the universitys having come into a relatively large sum of money from recently acquired timber lands in south Mississippi.[1]

PART II - IMPLANTATION AND EARLY DEVELOPMENT

Finally, on June 1, 1903, by a special act of the Board of Trustees, a medical program was authorized; it was designed to offer the first two years of the recom-

mended medical courses.[2,5] The announcements or bulletins of the medical program which until 1956 were published as a component of the whole university catalogue are a prime source of information concerning the Anatomy Department.[7] Since the catalogues are styled as announcements for the forthcoming session, the information contained therein is obviously related to the previous year. So it is in the catalogue with announcements for the session of 1904-05 that we find under the heading of Medical courses of the University of Mississippi" this pertinent note, "the next session begins September 22, 1903, and ends June 7, 1904". A two year program is set forth which includes preparatory courses in biology, chemistry and physics as well as the more specialized courses which relate to medicine as an "applied science", embracing the equivalent of the first two years of a regular four year course, "such as is given at the best medical colleges". The opening paragraph, under the header General Scope and Purpose of the Course begins, "The laboratory and other facilities for the study of science in the University of Mississippi afford highly advantageous opportunities to young men who intend to study medicine as a profession." The following description is found under the header Plan of Instruction, "The work will consist of lectures, recitations, and laboratory exercises. Each day the student will be questioned carefully on assigned work of the previous day. The subjects will be taken up in the order of their natural sequence. During the first year most of the time will be devoted to the study of anatomy, chemistry, and biology though some attention will be given to physics and electricity in so far as these are applicable to medicine. The study of microscopic anatomy will proceed side by side with that of gross anatomy. The work in anatomy will consist of lectures, assigned reading, and careful dissections of cadavers by the student." Some general comments follow concerning the progress of the preparation; then the last paragraph concludes, "Since the success of a physician depends upon his power of independent thought and the cultivation of the research spirit, in all of the work in the school of medicine special importance will be attached to personal effort on the part of a student". Under the header, Courses of Study, courses are listed for "First Year" and "Second Year". Six courses are listed for the first year including, Anatomy, with 3 recitations per week and 10 laboratory work hours per week, and Histology with 2 recitations per week and 4½ laboratory work hours per week. In the second year, with 9 courses listed there appears Anatomy (1st and 2nd Terms) with 2 recitations per week and 6 laboratory work hours per week. Detailed course descriptions follow. Under the heading, Histology, with Doctor Leathers listed as Professor, "[a 1,2,3]. Histology. The object of this course is to give a sound theoretical knowledge of normal histology and at the same time a clear comprehension of the methods of histological technique by actual practice in hardening, staining and mounting. Each student will be required to make a number of preparations. A careful microscopic study of each portion of the vertebrate body will be made with corresponding drawing and notes. Both a written and practical examination will be held at the end of each term." Dr. Leathers is also listed as the Professor of Biology and of Physiology, along with a Mr. Fulton. Under the heading, Anatomy, with Doctor Bullitt listed as Professor. "[a 1,2,3]The course will consist of didactic lectures, and of dissections of the human body. The lectures will cover osteology and all the soft parts; and all things described will be shown by actual dissection. At the end of the sessions a written examination will be held, covering the entire course. For the practical work the class will be divided into small sections. Each student will be required to do careful dissection upon all parts of the body, and at intervals will stand practical examinations upon the cadaver. Daily demonstrations will be made to each section. Frequent quizzes will be held. This work will be under the personal supervision of the professor. "Courses for the second year": [b 1, 2]. The work in this year will be chiefly of a practical nature. The student will review the work of the first year, and in addition will make numerous dissections with reference to regional and surgical anatomy. Such lectures and demonstrations as are necessary to a clear appreciation of this work will be given". Doctor Bullitt is also listed as the Professor of Pathology and of Bacteriology.

Under the heading, Text and Reference Books, "The cost of a set of text-books on all the branches required in the two years' course will not be greater than thirty dollars." Specific recommendations for histology are "Bohn and von Daviddoff (Huber's Translation), Schaper's Edition of Stohr's (Bilstein's Translation), Szymonowicz and MacCallum". For Anatomy, "Gray (Colored Plates), Morris, Towles (Christian)"

There is an itemization of costs under the heading, Annual Expenses in the Medical Department which includes such items as, "Board with lodging may be had in private families near the University at $10.00 to $16.00 per month. Board, meals only, $10.00 per month". A concluding statement is as follows, "Necessary expenses for session of nine months, not including books or clothing, will not exceed, in the medical school, $200.00 to $250.00.

The first faculty consisted of sixteen individuals including the Chancellor of the University as administrative officer. One of the sixteen was Waller Smith Leathers, M.D. who was listed as Professor of Histology, Biology and Physiology (Fig 3).[16] Dr. Leathers was a native of Virginia; received a bachelor's degree from the University of Virginia in 1892 and an M.D. there in 1895. After receiving his M.D., his first job was as Assistant Professor of Biology at the University of Mississippi. He left after one year (1895-96) to study at Johns Hopkins. He was on the biology faculty at the Miller School in Virginia and the University of South Carolina for one year each, then returned to the University of Mississippi in 1899, as Professor of Biology, Physiology and Geology. Each of these subject areas are sometimes referred to as "department of" with Leathers as "chairman" of each. When, in 1908, Leathers was named "Dean of the Department of Medicine", Geology was removed into a separate "department". Sometimes between 1910 and 1913, Physiology and Biology were also separated into independent "departments". Although Leathers was now Dean of the Department of Medicine, he retained the "chairmanship" of what is then referred to as the Department of Physiology and Histology, and continued to personally present the medical course in histology. During this period, (1903-1913) Dr. Leathers continued his studies in the general area of public health at various institutions such as Tulane and Chicago. In 1910, he was named Mississippi's first Director of Public Health. He held this position along with that of Dean of the Department of Medicine until 1924 when he resigned in order to take a position in the Department of Medicine at Vanderbilt. He became dean at Vanderbilt School of Medicine in 1928.

Another of the original sixteen faculty members was Dr. James Bell Bullitt, who was listed as Professor of Anatomy, Pathology and Bacteriology (Fig. 4).[16] Dr. Bullitt was a native of Kentucky; received both an A.B. (1894) and M.A. (1895) from Washington and Lee; then an M.D. from the University of Virginia in 1897. Doubltless, he met Waller Leathers while a medical student there, for after five years (1898-1903) as a demonstrator in anatomy at Virginia, he came to Mississippi to be a member of the first faculty of the new Medical Department. It is a commentary on the man, the times, and the place that Dr. Bullitt's special interests were hookworms, trichinosis and tuberculosis.

Sixteen students registered that fall (1903) for the Medical Department's first session.

Once admitted, students began a program consisting of three terms of academic work, each of which lasted

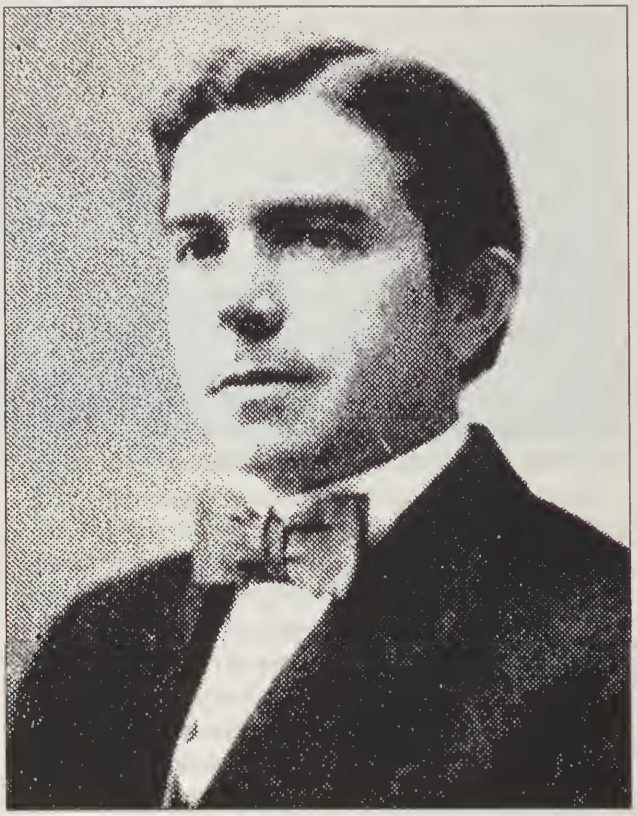


Fig 3. — Waller S. Leathers, M.D. Photograph Circa 1909.

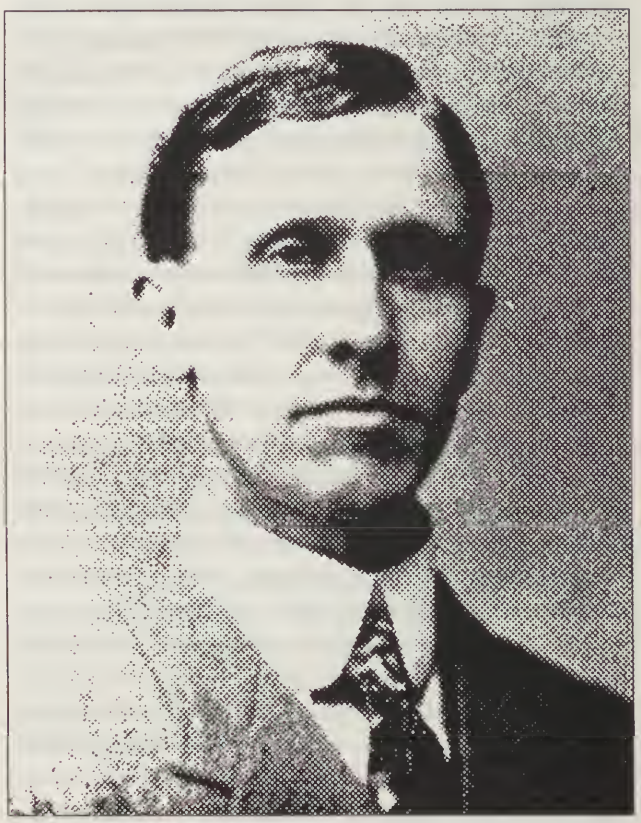


Fig 4. — James B. Bullitt, M.D. Photograph Circa 1909.

three months. Courses which included studies in anatomy, histology, physiology, bacteriology, pathology, materia medica, chemistry, hygiene and medical jurisprudence were presented primarily in the format of lectures and recitations although "some" laboratory work was required.[2] The "ample facilities" alluded to in the bulletin consisted of two classrooms and one small office located in one of the new wings recently added to the Lyceum Building.[1,2] A small frame building (construction made possible by a gift from Harry Howard, a member of the Board of Trustees) was built some fifty yards to the north of the Lyceum Building. The specific purpose of the building was for the dissection of cadavers. The university librarian, a Mrs. Elizabeth Murry Hunt, who incidently was an aunt of William Faulkner, occupied the recently (1889) constructed library which was relatively close to the "anatomy building". She complained that "an unbearable stench emanated from the shack". Along with the support of some faculty members she demanded the immediate removal of the building and the smell. Apparently, a carefully staged inspection of the building revealed no bodies, but this action only partially pacified these disgruntled souls.[2]

The scanty equipment available was mostly borrowed from other departments. Purchase of enough microscopes to meet the needs of the original sixteen students absorbed the bulk of the limited budget, leaving less than $500.00 for supplies and equipment during the first year. It had not been sufficient to permit the purchase of cadavers for dissection and the faculty had been unwilling from the start to resort to the ancient and time honored practice of grave robbing; budgetary limitations precluded dealing with professional resurrection agents. Finally, the Memphis Medical College, an institution founded in 1853 with several of its original faculty having previously been employed by the University of Mississippi,[3] conveniently (and probably illegally since the Mississippi code specifically forbade purchase of bodies from medical schools in other states, or from any source, actually) sent several bodies to Oxford, supposedly for burial; a service postponed until the cadaver had been dissected.[2]

According to catalogue retrospectives,[5] the Medical Department had seen during its first six years "a steady increase in attendance, and the quality of the student has naturally improved". For whatever reason, more space was requested of the 1905 state legislature and a new building (three stories and a full basement) was constructed to the left of the Lyceum, across the grove from the new library building. It was occupied during the 1906-07 session. This building which was



Fig 2. — Science Building, University of Mississippi, Oxford. Photograph Circa 1909.

designated, Science Hall, may have been intended for sciences other than the medical department, but the design of the interior certainly reflected specific needs of courses like gross anatomy, and the medical department with its collateral courses such as histology, occupied almost the entire building (Fig. 2). A storage vat for preserving and storing cadavers was located in the basement. An adjacent elevator shaft (which never saw an elevator) was used, with the aid of a block and tackle, to hoist the bodies from the basement storage area to the third floor gross lab area.

During the same year in which the medical department occupied its new building (1906) the state legislature approved an amendment to a bill pertaining to the University of Mississippi entitled, Anatomical material for medical department.[9] The bill in all likelihood was authored and promoted by Dr. Leathers who was shortly to become the first Dean of the Medical Department, and who was influential in forming the State Board of Health. He would become its first Director in 1910. The amendment was concise and to the point. It directed that the State Board of Health be responsible for all unclaimed bodies (except Confederate soldiers) of individuals dying in hospitals supported in whole or part by the state in seeing that such bodies be delivered to duly authorized representatives of the state university for anatomical purposes. That any such body, "so delivered shall be properly and decently removed at the expense of the University, by said authorized representatives, in a coffin, so as to be concealed from public gaze, and shall be transported under such regulations as the State Board of Health shall prescribe, and after use for strictly necessary medical study in the medical department of the state university it shall be decently interred at the expense of the university". Hospital authorities, the secretary of the

State Board of Health, and the Chancellor of the University were all directed to keep records "of each and every dead human body so delivered and used."

The terseness of this "anatomical material" amendment belied the fact that there were at least three statues elsewhere in the Mississippi Code dealing with "dead bodies" as in the disinterment of or "grave robbing" sense.[11] They were particularly pertinent with regard to anatomical material, and harked back to the 18th and 19th century English and Scottish medical schools and their innovative ways of obtaining bodies for dissection. One statute read, in part, "Dead bodies—Disinterment for sale or wantonness—Every person who shall remove the dead body of any human being from the grave or other place of interment for purpose of selling the same", etc. would, if convicted, be imprisoned "not to exceed five years or fined five hundred dollars, or both". Next, "Dead bodies—buying or receiving with knowledge—any person who shall purchase or receive the dead body of any human being knowing the same to have been disinterred contrary to the last section" would receive the same punishment. Then follows, "Dead bodies—opening graves for certain purposes—any person who shall open a grave or other place of interment with intent to use the dead body of any human being for the purpose of selling the same, or for the purpose of dissection," etc., was to be imprisoned in the penitentiary not to exceed two years, or fined three hundred dollars, or both.

The "donated" indigent bodies were shipped to Oxford via train. Primary source of the bodies apparently was the "lunatic" asylum located in Jackson (Fig. 13). Transporting the bodies from the railroad depot to the campus was a duty of a colored porter who deigned to carry out this duty at night. While this practice was most appropriate in a public relations sense it became the basis for an aura which came to be associated with the Science Building, including reports of "weird" noises emanating from the storage vat, elevator shaft and gross lab.[2]

If you correct for names of medical students and anatomy faculty, the following account (as related by Jerry Hughes, a freshman in 1954) of moving cadavers from the basement vats to the third floor anatomy lab, could just as well have taken place in 1907.[2] The location and circumstances are the same. Hughes describes the procedure as follows: "I suppose that every first year medical student is ambivalent, both elated, and apprehensive when "CADAVER DAY" arrives. The Anatomy Building on the Ole Miss campus had a closed, windowless shaft on the west wall, about three feet square (like an air-shaft), which extended from the basement to the third floor, it was necessary to tie a rope under the arms



Fig 13. — Mississippi State Insane Hospital 1855-1935, Jackson. Sketch Circa 1860

of the cadaver, give a tug on the rope to alert the students on the third floor to pull the cadaver up. The rope was about 3/4" in diameter, and went from the basement and ran through a pulley mounted in the ceiling at the top of the shaft...The students on the third floor after hauling away, would then pull the cadaver into the room, and place it on an empty dissecting table.

In the third floor classroom, as we prepared to go down to get cadavers, Dr. Hogg asked for volunteers to accompany him to the basement, several of us trooped down behind him, single file, down three floors, down the wooden stair case, which was so highly varnished that it looked wet. It smelled of floor cleaner and furniture polish. The cadaver storage area had a bare concrete floor, a small up-high window and a simple unpainted wooden table about 2.5 x 6.5 feet which was used to prepare the cadavers prior to placing them in the tank. Dr. Ward did most of this preparation. My impression of the source of cadavers in 1954 was that primarily, they were unclaimed bodies, from the state hospitals. Whitfield seemed to be the largest source. An unpainted formalin-filled concrete tank stood against the opposite wall and had a heavy, hinged, wooden top. The room smelled of dust, rat urine, floor cleaner and formaldehyde.

With little wasted motion and no ceremony, Dr. Hogg put on long, heavy, black rubber gloves, walked over to the tank, lifted the wooden top, reached under the surface and grasped the arm of a cadaver and started to pull it to the surface. There was complete silence, no one made a move. I remember I was waiting for instructions, from Dr. Hogg to tell us "what to do." Prior to making the trip downstairs, there had been no "drill" about how we were going to proceed in retrieving the cadavers. In other words we were all "hanging-back". I think that "cowardly" is the serviceable word here. Dr. Hogg, without raising his head, looked up over his steel-rim glasses,



Fig 5. — Anatomy Lab, University of Mississipi, Oxford. Photograph Circa 1907.

without a word, waiting for help. No one moved, until my classmate, George Ball, in guilty haste, suddenly stepped forward, grabbed the opposite arm and together he and Hogg began pulling the cadaver to the side of the tank.

The move by George opened the "flood-gates" of assistance, we were almost pushing each other out of the way to, "get in there and help", to lift that cadaver from the tank and transfer it to the gurney, a journey of about six feet, in preparation for the trip up the "resurrection shaft".

After the rope was tied around and under the arms of the cadaver, I pulled on it, alerting the third floor group to "haul-away". As the body ascended in the shaft, I stuck my head in and looked up, it was twisting slowly at the end of the rope...I saw it coming, but before I could move, a drop of formaldehyde hit me in the right eye. Since there was a lavatory in an adjoining room; I rushed in there and flushed my eye with water. The cadaver was on "our" dissecting table when we all got back to the third floor. My lab partners were Bobby King, William Livingstone and Billy Taylor. There were seven dissecting tables on the third floor for the 28 people in the class.

Catalogues for the years immediately following the occupation of the new building describe the available spaces.

The gross anatomy laboratory occupied four rooms on the east end of the third floor of Science Hall (Fig. 5). The general dissection area "was well lighted, having windows on three sides at a distance of four feet apart, and a large skylight. It was equipped with tables, sinks, and necessary appliances for a class of sixty." Additionally,



Fig 6. — Histology Lab, Science Building, University of Mississipi, Oxford. Photograph Circa 1907.

there was a wash-up and locker space and a separate room for "work of the second year anatomy." An adjacent amphitheater type lecture room had a seating capacity of forty-five.

An histology laboratory, described as "well equipped for both elementary and advanced" is not specifically located, but since histology was the responsibility of the Physiology "department' it is most likely that this lab occupied the east end of the second floor (Fig. 6). The physiology laboratory is said to occupy the west end of the second floor.

The embryology laboratory, a responsibility of the Biology department is said to occupy "a large, excellently lighted room on the first floor of Science Hall". This was probably the west end of the first floor.



Fig 7. — Joseph O. Crider, M.D. Photograph Circa 1915.

The beginning of the Medical Department in 1903 was propitious in that a drastic revision of standards had swept across the nation in the previous two decades.[2,4] This revolution was particularly inspired by the innovative Johns Hopkins University (est. in 1876) whose influence had reached even onto the hinterlands at Oxford in that the first dean of the medical program, Leathers, had done graduate work at Hopkins. A nationwide inspection of medical schools by Abraham Flexner was sponsored by the Carnegie Foundation.[4] In the report of Flexner's visit to the Oxford campus in November of 1909 (official report released in 1910) he stated that there was an enrollment of 39 with a faculty, including assistants, of 14. Only the laboratories in anatomy and physiology were described as "adequate to the needs of the instruction offered"; others such as pathology and biochemistry were inadequate.[2,6]

After the Flexner report, some effort was made to upgrade the quality of teaching in the Medical Department. Both Leathers and Bullitt were permitted (1909) to employ advanced students as assistants in their various course. Leathers was further relieved of some of his undergraduate teaching responsibilities. Sometime between 1910 and 1913, the Department of Biology and Physiology was divided. Dr. Leathers retained chairmanship of a Department of Physiology and Histology. Joseph Otterbein Crider with an MD from Virginia (1912) was one of several individuals hired (1913) to assist Leathers (Fig. 7). As Professor of Physiology, Crider was responsible for the histology course; additionally, he was made assistant dean (1916). This arrangement of a combined physiology and histology department continued until 1926, when Dr. J.B. Looper was made Professor of Histology and Embryology in the Department of Anatomy. Orren Williams Hyman was hired (1912) as an Assistant Professor of Biology to assist Leathers in the instruction of histology and embryology. In 1912, embryology was established as a separate course and taught, as such, for the first time by Hyman. Hyman , who had a BA (1910) an MA (1911) from the University of North Carolina, was typical of the young men who were hired in junior positions in the earlier years of the school, staying a short while and then move on. After a year, Hyman went to UT in Memphis, where he taught histology and embryology (1913-19). He continued his education at Princeton, where his research interest was in the cytology of germ cells; he received a PH.. D there in 1921. Afterwards, he returned to Tennessee and became Dean of College of Medicine in 1926.[16]

After Hyman, embryology was taught by James William Buchanan, an assistant professor of Biology. Buchanan, at the time had a B.S. from the University of Ohio. After teaching the embryology course for two years he went to the University of Chicago and received a Ph.D. in 1921. Eventually, after holding several instructorships, including one at Yale, he became Chairman of the Department of Zoology at Northwestern University.[16]

In 1913, the study of the central nervous system and organs of special senses was separated from gross as a special subdivision, and taught, along with "topographical anatomy", in the second year. It was 1925, before the anatomy of the nervous system appeared in the catalogue as a separate course and was "dignified' by calling it, neuro-anatomy.[8]

In 1915, embryology was transferred from the Department of Physiology and Histology to the Department of Biology and was taught by this department until 1926 when it was transferred to the Department of Anatomy and was taught by Dr. Looper.

Dr. Bullit resigned in 1913 to accept a position as Professor of Pathology at the University of North Carolina in Chapel Hill, a position which he held until retirement in 1947. Dr Bullit was held in such high esteem at Chapel Hill that the History of Medicine Society there is named the Bullit Society in his honor.

Dr. Clarence Ladelle Andrews who had just received his MD from Johns Hopkins (1912) took over the gross anatomy course as acting professor for the academic year, 1913-14.[19] After this one year he resigned to enter the private practice of internal medicine in Atlantic

City, N.J. During a long and distinguished medical career he was active in several professional societies, holding offices at the local, state and national levels. He died at age 80 of recurrent cerebral thrombosis.

Subsequent to 1913, the qualifications of the professional staff began to be raised, and the number of subjects for which one individual was responsible was reduced.[8]

In the catalogue of 1915-16 (dated, May 1916) we note that "the School of Medicine, created by the Board of Trustees in 1903, has been in existence thirteen years", and "had held membership in the Association of the American Medical colleges since 1904". In scheduling, the description of courses, and where the courses are taught, the most significant difference from previous catalogues seems to be in the frequent change of instructors. A steady stream of young men arrived, usually without a terminal degree, remained for a year or two, then moved on to complete their education. Under the heading, Plan of Instruction, "During the first year the time will be devoted to the study of anatomy, histology, chemistry, and embryology. The study of microscopic anatomy will proceed along with that of gross anatomy". The course description for anatomy (Prof. Strong) concludes, "about April 1st, work in neurology is begun, and this occupies the remainder of the Spring term. The brain and spinal cord are studied in detail." The course description for histology (Prof. Leathers, Associate Prof. Crider, and Mr. Collette) concludes, "He is required to make drawings of each specimen studied." The Embryology course description (Associate Prof. Griffith) concludes with, "The facts considered in lecture will be verified in the laboratory by study of frog, chick and mammalian embryos."

This pattern continues with little change save for the flow pattern of instructors, including an infrequent female, particularly in histology and embryology, always noting the use of electric lights (this item continues to be included in the catalogues through 1940-41).

During the two academic years 1914-16, Dr. Reuben Myron Strong, with a Ph.D. from Harvard (1901), was the Professor of Gross Anatomy.[16] At the end of this period, he left for Vanderbilt, where he was professor of microscopic anatomy for two years. In 1918 he became Professor and Chairman of the Department of Anatomy at the Loyola University School of Medicine (Stritch) in Chicago, serving there until his retirement in 1946. He had a wide range of research interests from ossification of the human skeleton to the structure of the human brain.

Dr. Charles Francis De Garis, followed Dr Strong as Professor of Gross Anatomy (1917-1922).[16] He had received the MD degree from Washington University School of Medicine (St. Louis) in 1912. He was an intern and resident pathologist at the St. Louis City Hospital in 1912-13 and an instructor in anatomy at Wisconsin (1913-1916), before coming to Mississippi. Dr. De Garis is credited with bringing stability to the "department' and raising the standards of the different anatomical courses. During his tenure, Dr. De Garis became interested in variations of the vascular system and gathered the data for the first of a long series of papers in that field. In 1923 he left to continue his education at Johns Hopkins where he received an MA (1926) and a Ph.D. (Zoology) in 1928. While at Hopkins (1923-36) he taught gross anatomy and embryology. In 1936 he went to the University of Oklahoma School of medicine as Chairman of the Department of Anatomy, retiring from academic life in 1957.

The euphoria, or possibly a sigh of relief, that had accompanied the young department/school in its new "state of the art" quarters was, in reality, short lived. Mississippi economics (boll weevils and low cotton prices) and associated politics conspired to set a pattern of grossly inadequate funding and staffing. Enrollment, however, steadily increased, and immediately after WWI, the enrollment almost doubled (a peak of 70 students) with no comparable increase in faculty or facilities.[2] The political scene was ugly. Accrediting agencies began to more closely and more frequently examine the situation, reporting that the medical school had failed to keep step with the rapidly changing trends in medical teaching. Generally, medical schools, were now expected to also function, as research centers, and increased laboratory experience for students was emphasized. Reflecting the nation-wide "great depression", legislative funding was even further reduced.

Byron Lewis Robinson, with a BA (1914) and MA (1917) from Wisconsin, was teaching in various areas including hygiene, as well as assisting Dr. De Garis in gross (1916-22).[16] In 1922-23 he assumed responsibility for the gross course, as acting professor. After one year he resigned to continue his education at Minnesota where he received as MD in 1924. Later, he became Professor of Anatomy in the School of Medicine at Arkansas (1925) and was Dean there from 1941-46.

In 1924, Dr. De Garis resigned. His place as Professor of Anatomy (gross) was taken by Dr. Philip Lee Mull, (MD, 1898, Kentucky School of Medicine, Louisville) (Fig. 8). In the two years preceding his arrival in Mississippi , Dr. Mull had been Professor of Anatomy at Louisville. In the same year (1924), Dr. Joseph O. Crider succeeded Dr. Leathers, Dean of the Medical Depart-

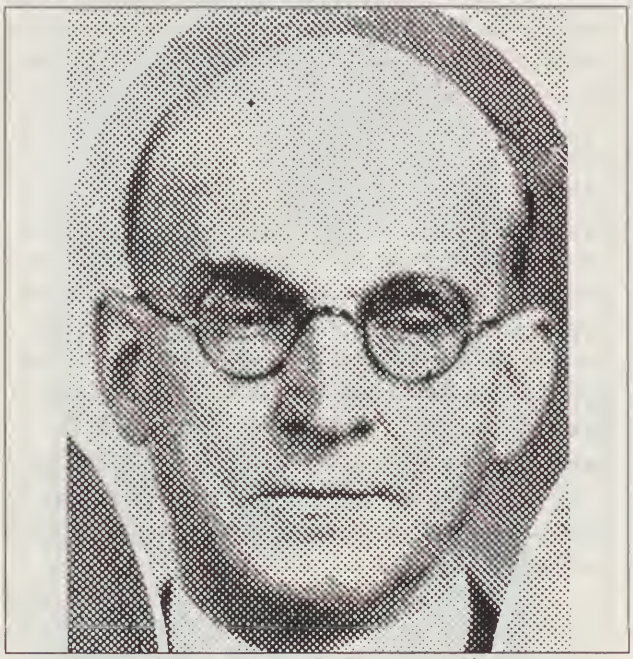


Fig 8. — Philip Lee Mull, M.D. Photograph Circa 1931.



Fig 9. — James B. Looper, M.D. Photograph Circa 1944.

ment, and assumed the new title, Dean of the Medical School.

The catalogue of 1925-26 adds to the off repeated script, the following, "Prizes: Mr. James A Pinnex of Amory, Miss. offers a prize of $10.00 for the first-year student of 1926-27, who makes the best grade in anatomy". This munificent offer appears again the following year; then disappears without a trace.[7]

In 1927, James Burdine Looper (BS, 1922, Furman; MS., 1925, PhD 1927, University of Virginia) was added to the staff as Assistant Professor to assist in the teaching of histology and embryology (Fig. 9).[16] Dr. Looper was apparently relieving Dean Crider of his teaching duties in histology and embryology. Crider, however, continued to teach physiology. At this time the embryology lab is located on the second floor of the Science Building. Within three years, Dr. Looper is promoted to Professor of Histology and Embryology, and has several teaching assistants for these courses. The 1934 catalogue states, under the heading of "Histology and Embryology Lab this Department occupies five rooms on the west end of the 4th floor of the old medical building". Under the header, "Anatomy Lab - the lecture room has a seating capacity of 40 students and is shared with the Department of Histology and Embryology". All areas are said to have electric lights.

PART III - FETAL

Dean Crider was a victim of the great Bilbo purge of 1930,[3] amidst a great wash of threats of loss of accreditation from the AAMC and AMA. Dean Crider was not "reinstated" because, according to Chancellor Powers, he did not possess acceptable qualifications, and had not been able to attract a sufficient number of students to the University. In fact, however, the number of students was high enough to severely stress the limited resources of the school. The AAMC was even more specific in chastising Crider, charging that he failed to appreciate the current thrust in medical education.[2] Chancellor Powers was unable to find anyone willing to fill the Dean's position and, with increasing pressure from the AMA and the AAMC, was forced to reconsider Crider. Ironically, just two days before classes were to begin in the Fall of 1930, Crider resigned to accept a position at Jefferson Medical College in Philadelphia as Professor of Physiology and Assistant Dean. He remained at Jefferson until retirement in 1953.

As a result of these upheavals, the school was placed on probation. Probation was precarious enough, but loss of all official recognition as threatened by these agencies would have meant that graduates of the two year school would/could not be accepted by any four year school. Prospective students were reluctant to take a chance on the school's survival and consequently the number of medical students fell from a peak of 70 in 1926-27 to 45 in 1932-33. In the 1930-31 session the entire medical faculty was reduced to seven professors, including the dean.[2]

Chancellor Powers, rebuffed by Crider's abrupt and final departure, still could find no one interested in the

Dean's position. At the last minute, Dr. Mull, Professor of Anatomy, was persuaded to accept the onerous task of administrating the battered faculty and school.

Some attempt to "revitalize" the school had been expressed in a proposed new medical building with construction to begin in 1929, but the building was not completed and occupied until 1934.[2,5] There were some minor alterations/repairs to the now "old " Science Hall. Gross anatomy, along with histology and embryology, remained there, taking over the entire top floor. In a current catalogue, under Anatomy Lab: ".....the professor's office is connected with both the dissecting room and lecture room." The recently appropriated funds for "revitalization" went mostly to furnish the new building.

The accrediting agencies were particularly critical of the fact that an attempt was made in 1930 to lower the Dean's salary from $4,500 to $3,900. With the ultimate irony being that for the first nine months of 1931, the newly appointed Dean Mull received no salary at all. In 1932, threats by the legislature to close the medical school were almost successful.[2]

Dean Mull immediately began a crusade to salvage the embattled medical school. He lobbied the AAMC and AMA who now threatened to suspend the school completely. He traveled the State, mostly at his own expense, speaking to medical societies and contacting local physicians for support. His most significant supporter was Dr. John Culley, the University physician, who, incidently, was president of the state medical association during 1932. His enthusiastic efforts in defense of Dean Mull and the medical school were major reinforcements to the cause. Considerable coverage by the press concerning the crisis and Dr. Mull's efforts helped spread the word through out the state.

During this chaotic period some unidentified individual wrote a letter to the Board of Trustees accusing Mull of being a drunkard and of spending an inordinate amount of time in the Oxford hospital, "drying out". Chancellor Hume was requested to investigate the charges (July 16, 1934). Hume, who had been ousted in the Bilbo purge, had by now been reinstated, replacing the interim Chancellor Powers. What Hume learned was, in truth that Dean Mull, a bachelor living alone in rented quarters, had had serious surgery, and had of necessity stayed in the hospital for a prolonged period of time in order to receive the proper care required for his recovery. Further, that of several individuals, who were personally acquainted with Dr. Mull and who had been questioned concerning Dr. Mull's social habits, only one could recall, and that in a single instance, ever seeing Mull "possibly" inebriated. Dean Mull was completely exonerated of all the charges.[10]

While at the time, Dean Mull was universally acknowledged as having almost single- handedly saved the medical school from extinction, this monumental accomplishment currently seems forgotten, and others have been given credit. No building bears his name, and no statue has been erected. A pity!

Dean Mull resigned, effective June 1 1935, after five years at this "particularly trying post". He did, however, remain on the faculty resuming his teaching duties as Professor of Anatomy. He retired after two years in this capacity, moving to Conway, Arkansas where it was noted in the catalogue that "he was not in practice". He died in Indiana on June 10, 1954, at the age of 81.

The situation of the institution was still so unstable in the Fall of 1935, that no freshman class of medical students was admitted.[2]

During this faltering period of academic hiatus, Dr. Looper took a "leave of absence". He went to the University of Chicago School of Medicine where he received an MD 1937, apparently never relinquishing his position as Professor of Histology and Embryology. The position of Professor of Anatomy in unoccupied, or "to be filled" in the 1935-36 session; for the 1936-37 session John James Fahey (MD, 1931, Ohio State) is listed (along with Dr. Looper) as Professor of Anatomy. Fahey stayed for only one year, leaving to enter the practice of orthopedic surgery in Chicago.

All the turmoil which began in the Summer of 1930 ultimately resulted in the complete reorganization of the school with benefit in "every aspect of medical education, the physical plant, the scientific equipment, the faculty, the budget, and the curriculum".[2]

Upon Dr. Loopers return from his leave of absence, his title is changed to Professor of Anatomy. The catalogue of 1937 has dramatically changed its format and now clearly defines and identifies (for the first time) a Department of Anatomy. Under the Department of Anatomy are listed the separate courses of gross, microscopic, neuro and developmental anatomy. The entire staff for all of these courses consists of Dr. Looper and Dr. A.R. Buchanan.

Dr. Archibald Ray Buchanan had received a BS from Iowa in 1929, and an MD there in 1933. He was an instructor in anatomy at Iowa from 1929-1936; then went to Northwestern where he studied neuroanatomy and received an MS in 1937.[16]

Taking advantage of the funding, albeit limited, which became available with the so called, "reorganization", Dr. Looper was able to purchase a few pieces of equipment for the department, particularly in setting up a



Fig 10. — David S. Pankratz, M.D. Photograph Circa 1958.

histotechnique lab. These purchases represented a 100% increase in the departmental inventory. Of particular note, Dr. Looper procured several early human embryos which were serially sectioned and became a critical core of the student embryology slide sets. A rare, approximately twelve day old specimen with implantation site intact, became known as the Looper Embryo. Another factor in the "reorganization" was an emphasis on research oriented medical education. Dr. Looper responded to this encouragement with histological studies which ranged from bantam caeca to alligator thymus. In the catalogue of 1940-41, Dr. Looper is listed as "Chairman of Anatomy"; this is the first time that that title has been used.

When Dean Billy S. Guyton (who had succeeded Dr. Mull) left the Medical School for Military Service in 1943, Dr. Looper was appointed interim Dean. He served in this capacity for two years, in addition to his position as Chairman of Anatomy. In failing health, Dr. Looper retired to Senatobia, MS in 1945, dying in 1950 at age 50 of cirrhosis of the liver.

In 1939, Dr. Buchanan resigned to become associate professor of Anatomy at the University of Colorado School of Medicine. He is made Professor there in 1946 , and in 1951 became head of the Anatomy Department. He also served as assistant Dean from 1950-55. He retired in 1962.

On Dr. Buchanan's departure, this position was filled by David Schultz Pankratz (BA, 1923, Bethel College, MA, 1927, Ph.D., 1929, Kansas) who had just received an MD degree from the University of Chicago School of Medicine (1938) (Fig. 10).[16,22] In the catalogue of 1939-40 (published in April, 1940) the new and improved departmental format which first appeared in 1937 is further enhanced by critically revised course descriptions. These changes reflected the arrival of Dr. Pancratz. Under the departmental title, Anatomy, courses are described as follows:

"Gross Anatomy. The course is conducted through dissection, quizzed, and explanatory lectures, utilizing a total of fifteen hours a week during the first semester and nine hours a week throughout the second semester for the total of 384 clock hours. The course is divided into five sections as follows: (1) Upper extremities, 90 hours; (2) Lower extremities, 105 hours; (3) Viscera of thorax and abdomen, 81 hours; (4) Perineum, 9 hours; (5) Head and neck, 99 hours. Cadavers are issued in the ratio of one to two students. Each student is thus responsible for a complete dissection of one lateral half of the cadaver. Weekly quizzes are given over the work, and at least one examination is given which covers the work of each section."

"Neuro-anatomy. This course consists of fifteen hours a week of quizzes, explanatory lectures, and laboratory work, for six weeks at the close of the second semester. It begins with the consideration of simple neural structures and activities, and laboratory work on the spinal cord. Following this, the human brain is studied in contour, by dissection, and in gross cross sections. The latter part of the course is devoted to a study of stained sections of the human brain stem, and to a consideration of the fiber tracts."

"Applied Anatomy. The course is conducted through two hours a week of papers and demonstrations by the students throughout the first semester. Practical application of anatomical relationships is stressed, especially those which are important in surgery and in certain infectious processes. Surgical approaches, taking into account all anatomical structures involved, are demonstrated on the cadaver."

"Microscopic Anatomy (Histology). The object of this course is to give a sound knowledge of normal histology. During the first semester and until March 1st in the second semester, two hours a week are used in lectures and quizzes, and six hours a week are devoted to the microscopic study of the tissues and organs of the vertebrate body. For this work the student is supplied with microscopic sections previously prepared and ready for study. He is required to make drawings of each specimen studied".

"Developmental Anatomy (Embryology). This

course begins on March 1 of the first year and extends to the end of the session. It consists of two hours a week of quizzes and explanatory lectures and six hours a week of laboratory work. Lectures cover the phenomena of cell-division, spermatogenesis, oogenesis, fertilization, cleavage, development of the germ layers, and organogeny. The facts considered in the lectures will be verified in the laboratory. This course is open to medical students only."

Under the general header, Laboratories and Museum, is the most detailed and clearly presented description thus far of the space allocated to the Anatomy Department in the Science Building.

"Anatomical Laboratory. The gross anatomy laboratory is sufficiently large to accommodate thirty students. It is well lighted, having windows on three sides and a large skylight in addition. Artificial lighting is also adequate. Modern humidor dissecting tables are utilized. Anatomical charts, models, x-rays and large number of complete skeletons (non-articulated) are availeable. One well-preserved cadaver is supplied for each two students. The lecture room (equipped with screen and three projectors) has capacity for forty students. Articulated skeletons are also a part of the teaching equipment".

"For the laboratory work in neuro-anatomy, the histology and embryology room is used. Adequate table space, charts, and projection apparatus are available to the student. Sets of prepared slides of representative levels of the spinal cord and brain stem are issued to each student".

"Histological and Embryological Laboratory. This department occupies five rooms on the west end of the fourth floor of the Science Building and, in addition, shares the lecture room on that floor with gross anatomy and neuro-anatomy. The general laboratory is a large room with windows on three sides and is well-supplied with electric lights. A preparation room and a room for small laboratory animals adjoin the laboratory. There is an abundance of equipment and supplies for teaching histology and embryology, including modern microtomes, stains, reagents, instruments for dissection, microscopes, and an abundance of embryological slides, a large delineascope, and other necessary equipment".

"A modern animal surgery room adjoins the histology and embryology laboratory. It is supplied with an electric autoclave, two electric instrument sterilizers, a high temperature air sterilizer, animal boards, operation table, General Electric refrigerator, and a complete supply of surgical instruments". Note that this catalogue information does not include the large histo-technique room on the first floor, occupied by Malcolm Franklin.

Dr. Pancratz represented the ultimate American success story. He was born in a sod house on an Indian reservation in Oklahoma (1898). He began his education in a one-room school house and working in the wheat fields, put himself through Bethel College (Oklahoma). He then entered the University of Kansas, receiving the M.A. and Ph.D. degrees, both in anatomy, from that university. In 1928 and 1929, he served as a summer research fellow at the Wistar Institute of Anatomy and Biology. His research interests and activities primarily related to the nervous system, particularly cranial nerve components and development of fetal motor activity. After receiving his Ph.D. (1929) he was appointed an Assistant Professor of Anatomy at the University of Tennessee College of Medicine at Memphis. During summers for four years and a years leave of absence from Tennessee, he studied medicine at the University of Chicago, receiving the MD degree in 1938.

In the fall of 1939 he came to the University of Mississippi School of Medicine as Professor of Anatomy. His teaching duties were in gross and neuroanatomy. He introduced new and innovative teaching methods with emphasis on visual materials. At his request the department purchased a 16 mm motion picture camera and a projector to show the film(s). He is also given credit for introducing the "pop" quiz, which was "administered" on a daily basis.

Upon Dr. Looper's retirement from his dual role as Dean and Chairman of Anatomy (1945), Dr. Pancratz was made acting Dean, in addition to his appointment as Chairman of Anatomy. The following year (1946) he was named Dean. This was the period of promoting and planning for a four year medical school, ultimately to be located in Jackson. Pancratz won much acclaim for selling the idea of a medical center for the State of Mississippi, for the physical layout of the center, and particularly for the selection of a clinical faculty. The duties of "deaning" were all encompassing, and while he retained the title, Professor of Anatomy, he was no longer directly involved with the anatomy courses.

One Pancratz story (as recalled by Jerry Hughes, freshman, 1954) says a great deal about Dr. Pancratz's persona. The episode has to do with the medical library which at the time occupied a large room in the "new " medical building. The library keeper, Meda Cole, had a little typewritten sign on the library door which was always kept closed, even in the daytime, which read, "Students studying in the library are requested to do so quietly". Some wise-guy, one night, changed the word studying to "studing". For some reason, this threw Miss Meda into a tizzy. She brought this self-declared insult to the attention of Dr. Pancratz, who after reflection,

called a meeting of all male medical students in all classes. There were four female students enrolled at the time. At the meeting, Dr. Pancratz solemnly declared that there were appropriate times and places for such activities, but the medical library wasn't one of them. His little talk took a hilarious turn when he declared that "my scrotum is just as big as anyone's, but lets keep things in their proper place". Needless to say, thereafter he was referred to in "sotto voce" as THE SCROTUM!

Dr. Pancratz became the first Director of the University Medical Center in Jackson in 1954, retiring from this position in 1960. After leaving the Medical Center, he became an Associate Professor of Psychiatry at the Tennessee College of Medicine and practiced psychiatry in the program of the Center of Health Sciences there. He retired once again in 1972 and returned to Oxford where he died in 1980.

Dr. Ray Janney Nichols (BA, MS College, 1926; Ph.D. U. Of Ill., 1935) was appointed to fill the void in histology created by Dr. Looper's retirement. Nichols was born in Hernando, MS, Feb. 7, 1906 (18). After receiving his BA from Mississippi College in Clinton, he was awarded a fellowship in biology at Yale University where he was a graduate student for two years. He was an instructor in biology at Union College (Schenectady, NY) for one year (28-29) before returning to Mississippi College as Professor and Chairman of the Department of Zoology. In 1932, he left Mississippi College in 1929 to complete his graduate work at the University of Illinois, again on fellowship; he received his Ph.D. there in 1935. In 1934, he accepted a position as Assistant Professor of Biology at the University of Mississippi and save for a years leave to study at the University of Chicago (1939) served in that capacity until 1944. Dr. Nichols' research interests were primarily in the area of the ecology of amphibia and reptiles, particularly with population and migration studies of toads.

In the fall of 1944, he was appointed Associate Professor of Microscopic Anatomy in the Anatomy Department. Logistically, this meant that he moved from the first to the fourth floor of the Science Building. He was promoted to Professor in 1946. Nichols was renowned as a skillful teacher, with a sharp wit and a great sense of humor and a pipe smoker. He had been known to slip in a slide of a stained leaf during histology practicals, chuckling at the expressions on the faces of the victims.

At the close of WWII (1946), Nichols was assigned the considerable task of University Administrator for Veterans Affairs. He was President of the Mississippi Academy of Science in 1950 and served on its Board of Trustees for several years thereafter. During this period



Fig 9. — Ira D. Hogg Ph.D. Photograph Circa 1958.

he played an important role in the organization and founding of the Gulf Coast Research Laboratory at Ocean Springs, MS. In 1951, he was appointed Director of Admissions and Secretary of the School of Medicine. Additionally, he was an active and driving force in the cultural activities on the campus and in Oxford.

In March of 1954, as the spring semester and histology began, Nichols developed severe and unrelenting headaches. With no improvement, he was referred to Memphis for a cerebral arteriogram which revealed a brain tumor. On exploratory surgery it was diagnosed as a glioblastoma. He was brought back to Oxford where medical students volunteered to sit with him at night to give his family some relief. He died on May 12, 1954, having been mentally unresponsive since the surgery.

When Pancratz became Dean, he sought out a former classmate from Kansas, Ira Dwight Hogg (BA, 1921; MA, 1923; PhD, 1926, U. Kansas) to take over the Anatomy Department (Fig. 11).

"In God we trusted, in Kansas we busted". Dr. Hogg, with that twinkle in his eye, used this expression to qualify his who, what, and where, he had come from. He was proud of the forebears who had endured the hardships of the land rush into Indian country, the sod houses, and the expanse of the great plains country. It had molded the integrity, work ethic, and stoicism of his personality. Hogg served in the U.S. Army in WWI. In 1918, he married Eva Leona Hottle, a local girl who with her sisters had traveled the state as gospel singers. If it was a marriage made in Kansas rather than in heaven, it

certainly seemed to have made for a long, compatible life together.

Dr. Hogg worked his way through graduate school as an assistant, and later as an instructor in anatomy at Kansas. The graduate training at Kansas was in a stimulating and productive atmosphere. At the time the Department of Anatomy there was a major center of research in what C. Judson Herrick described as the "embryology of behavior and the bodily apparatus involved in it". Hogg's life long interest in neuroembryology was deeply influenced by Henry C. Tracy and George E. Coghill at Kansas. Coghill was a renowned neuroembryologist who later went to the Wistar Institute in Philadelphia where Hogg studied in the summers of 1927, 1928, and 1929. On receiving his PhD (1926) he obtained a position as Assistant Professor of Anatomy at the University of Pittsburgh, School of Medicine or "Picksburg" as Hogg said it. There he was associated with Davenport Hooker, the Chairman of Anatomy, who was also a neuroscientist and who had been a student of Ross G. Harrison of Yale. It was from Pittsburgh that Hogg came to Oxford in 1946 as Professor and Chairman of the Department of Anatomy. He was hired at a staggering salary reputed to have been $5,000.00.

Dr. Hogg established himself as a tough, no-nonsense teacher/administrator, asking no one on the staff to do what he was not ready and willing to do himself. He was described in 1954 as "an impressive gentleman with silver-grey hair in a freshly laundered white lab coat, steel- rimmed glasses, and a mid-western accent". He had a slight ptosis of his left eyelid and on occasion would point this out by way of illustrating the anatomical explanation of the condition. He was good natured, never raised his voice and never lost his patience, no matter how dumb a question a student might pose. Perhaps the greatest tribute paid to Dr. Hogg was the profound respect and deep affection tendered and never forgotten by his students.

Dr. Hogg took a photograph of every student that he taught. His explanation, "when people gave him as a reference, he wanted a reminder of just who the individual was". He used his own camera, an ancient wooden one, standing on a wooden tripod, with a black accordion-like bellows to focus it. The camera used 5" x 7" sheet-film which was pre-loaded into a film holder. To focus the camera he had to bend over, put his head under a black cloth attachment at the back of the camera and look through a ground glass view finder while sliding the camera back and forth on a brass track. He processed the film in the darkroom himself. Hogg took each picture personally It was quite a production and was treated as an important occasion by both photographer and subject. It was likened to going before a firing squad, as students were called out of class, one at a time, to enter the histology lab where the camera was set up, and asked to be seated in a fixed chair. He focused, inserted the film and made the exposure while all the time carrying on a cheerful repartee, using a black rubber bulb on a long rubber tube, as a sort of cable release. Since Hogg, as Professor of Anatomy, had the power of intellectual life or death over each individual, to say that the photo session was not taken lightly, is a vast understatement. The photographs, along with copius notes which are sometimes very personal, still exist. They represent a time capsule of many practitioners over the state.

The following episode comes from Dr. Charles M. (Sonny) Dorrough, a freshman in 1950. It seems that Sonny's class was in the throes of embryology when duck season came along. Two of his classmates, Jare Barkley and Bill Hoffman, elected to skip class one fateful day and go duck hunting. Dr. Hogg, by design or intuition, elected that day to give the class a pop test; of course the two missed it. On the day that the graded tests were returned, everyone, including the duck hunters, got papers back. The papers received by the duck hunters had a drawing of two ducks with the notation by Dr. Hogg, "QUACK QUACK QUACK, the ducks will be back next year, and so will you"!

Hogg bore the brunt of the departmental teaching load being responsible for both gross and neuro, and after Nichols death he also took over the embryo course. This was in addition to his administrative duties, material preparation, etc. A part of "the sell" to the legislators for a four year school was to increase the number of medical students. During the years when two classes per year were admitted (1947-1956), the regimen was described by the devout Presbyterian, Hogg, as a "nightmare".

The budget was always tight and particularly so during the war years (WWII) and the years that followed. Chemicals for body preservation were difficult to come by. Dr. Hogg had heard that used motor oil would be suitable for such purposes and, considering the urgency of the situation, proceeded to fill the cadaver vat with this "practical solution". On a batch of poorly embalmed bodies, it didn't work. When the vat was pumped out onto the slope behind the Science Building, a greasy black slick, with an occasional clavicle or fibula, seared everything in its path. It looked like something from T.S. Elliot's Wasteland. Dr. Hogg's comment on this experiment was, "the less said about that, the better, we feel".[8]

In the catalogue of 1949-50 there appears for the first time a statement regarding a blurring of course lines

in anatomy. "The courses offered in anatomy have been placed in a block system consisting of 32 full 40-hour weeks of instruction and laboratory work for a total of 880 clock hours. The work in all phases of anatomy is clearly correlated in time although the lectures in different subjects are given by different professors. For the sake of the records examinations are given on the different subjects. Credit for the work is given in courses as listed below." The course list includes every course offered: gross, neuro, histo, embryo, and applied anatomy. In the 1952-53 catalogue a further qualification is added to the above, "These courses are interdependent and may not be taken separately." Key words here are "block", "correlated" and "interdependent", and while, theoretically, this arrangement might have seemed the most efficient usage of the department's hard-pressed time, it effectively cut out graduate students from other departments. Consequently, by the time the move is made to Jackson, the following modification is made, "students from other departments with specific interests may take separate components of anatomy." This latter form persisted as long as Hogg was in charge; it was deleted by 1958-59.

The department relied heavily on student assistants from the second year class and several who stayed on for a while after completing their second year. Two such individuals were: Warren W. Johnson, who was later associated with the pathology department of the University Medical Center, and G.A. Bynum, who became a skilled surgeon, practicing in Hattiesburg. A variant to this pattern (a non-medical student) was Jim Ward, who was employed as Associate Professor of Anatomy in 1946. He did not have a terminal degree, but had completed most of the required work for a PhD at the University of Minnesota. Under the rules of the University, he could not be employed for longer than two years without a terminal degree. Ward pleaded with the department to institute courses leading to a degree in anatomy. Responding to pressure, Dr. Hogg submitted a petition to this effect to the Dean, the Chancellor, the Board of Trustees and the graduate council. Permission was granted by all these entities and Ward was enrolled. In 1950, the first Ph.D. granted by the Anatomy Department, or by the medical school for that matter, was received by Ward. Dr. James Wellington Ward (BA, Ala., 1929; MA, Ala., 1932; MS, Miss. State, 1931; MS, U. Minn., 1947; Ph.D., U. Miss., 1950) was born in Weathersby, MS in 1904.[17] He had a fine outgoing, good-ole-boy personality. His ambition had led him from Simpson county to Alabama, Mississippi State and Minnesota, getting master's degrees at all of them, and finally to Oxford where critical staffing needs of the anatomy department created the nitch which led to his receiving the Medical Schools first Ph.D. In the interim, he had numerous jobs, mostly related to entomology and parasitology.

Ward did yeoman duties around the department, assisting in gross and neuro, and was responsible for the further embalming of incoming bodies. On Nichols death, he was assigned the histology course for its completion. The following incident dates from this period (1954). One day in histology lab Ward was lecturing on the liver. He asked the students to take slide #150 from the slide box and after giving them a minute to get the slide focused on the microscope, began talking about it, using notes and a slide projector. He described in great detail the microscopic anatomy of the liver. Nobody could see anything that he was describing. In desperation, one student looked at the slide list again; number 150 was listed as "thick skin from the heel of a Negro". The student interrupted Ward, saying "my slide says. . . ."; it turned out everybody but Ward had the wrong slide.

As the pressures of growing class size, multi-class years, and year round sessions increased, so did the teaching load. To bolster the hard pressed staff, Dean Pancratz and Dr. Hogg sought out their old teacher and mentor from Kansas, Henry C. Tracy, to take over the neuro course (1950). It is not clear whether Tracy needed the job to supplement a meager retirement. Because of his age, he could not be salaried as a state employee or be listed by an academic title. Presumably he was paid from outside grant funds, possibly from the Polio Foundation and was designated as an "associate" of the department. Henry Carroll Tracy (BA, Dartmouth, 1902; MA, Brown, 1905; PhD, Brown, 1910) was born in Hartfort, VT in 1879. It was while at Dartmouth that he became interested in the life habits of marine fishes; his doctoral dissertation was on the swim bladder of fishes. Dr. Tracy's first academic position was an instructorship in anatomy, histology and embryology at Northwestern University (1910-1912). In 1912 he joined the faculty at Marquette University as Professor of Anatomy and soon became chairman of the department. He remained there until 1920.[20]

George E. Coghill was looking for a "bright young man" to come to Kansas, so he informed C. Judson Herrick, in 1919. Herrick knew of "Hank" Tracy's work on the behavior of fishes and urged Coghill to consider him. Tracy's interest in the development of the nervous system in relation to behavior fitted into the over all program of Dr. Coghill's studies on Amblystoma, as well as Dr. Herrick's basic studies of the salamander brain.

Tracy became chairman at Kansas in 1926. In 1950, he retired after 30 years at Kansas and went to Oxford to teach neuroanatomy in the Anatomy Department of the medical school there. He spent many summers at Woods Hole Marine Biological Laboratories, concentrating on the nervous system of the toadfish.

Dr. Tracy was a gentleman, and an exceedingly effective teacher. On the first day of neuroanatomy course (in Oxford) he would open with, "Boys, I am eighty years old, and after reflection, I think that I can say without equivocation that life is just one damn thing after another".

Tracy also had a "demonstration" which he performed for each class. Standing on the lecture platform, he would remove his shirt and, with great concentration, flex the pectoralis muscle group, individually and bilaterally and the pectoralis major and minor muscles one at a time. Such control was impressive and must have required a great deal of time to master. He also had evolved a very efficient system for the lecture medium. He was stone deaf and talked slowly with a booming voice as he illustrated points with carefully constructed black board drawings. Students soon learned that there was no point in asking him a question since he couldn't hear them.

At the instigation of Tracy, a loan of 50 sets of neuroanatomy slides from the Anatomy Department of the University of Kansas was negotiated. The availability of these slides significantly enhanced the barely adequate neuro material of the Department.[8]

To say that Hank Tracy was something of a free spirit is to put it mildly, or "politically correct" in current parlance. One spring he left the campus to be gone for a week ostensibly to attend a conference at Woods Hole. A week passed, then another, with no word from Tracy. In the third week, just as concerned individuals were about to put out an all points bulletin, Tracy returned. Along with him was a new, very young wife, and a new red Pontiac. Always appreciative of a "nip", he had many friends on the Oxford scene and numbered among the elite group of William Faulkner's "drinking buddies".

Up the front steps of the Science building to the first floor and just inside and to the right of the entrance was a large square room. This space was utilized by the Anatomy Department as a special preparation lab, especially histo-technique, and was the domain of one Malcolm Franklin. It was a dark, cavernous place with open shelving all around filled with all sorts of glassware and various pieces of equipment. It reminded you of an alchemist's cell. Adding to this impression was a black cat which would stealthlly wind in and out among the flasks, beakers and cylinders, apparently never dislodging a single thing. The cat belonged to Gloria, Malcolm's then current girl friend (and later his wife) who was also black haired. The two of them fit nicely into the overall atmosphere.

Malcolm was unquestionably a nice sort of guy and obviously well qualified for his position as histo-technician for the department. He prepared, maintained and distributed the student slide sets, and was a presence in the lab when the histology course was in progress. Former students recall that at some point during the course, Malcolm would walk to the door of the lab and declare to the world, in general, that "life was no damn good". Although this outburst would cause Dr. Hogg, in his office nearby to wince, the periodic purgation seemed to have cleansed Malcolm's soul for the rest of the session.

Yet another of Malcolm's designated duties was the disposal of the remains of cadavers. Sometimes a short cut to the usual burial site was taken by way of nearby garbage cans destined for the Oxford dump. This caused much consternation within the local constabulary who had to deal with complaints from an irate public which were finding "body parts" in the city garbage dump.

Malcolm carried on an independent research program on liver parasites, collected from slaughter houses as far way as Clarksdale, and published a number of papers on his work.

The big problem for Malcolm was one of identity; he could never get away from his initial introduction as William Faulkner's stepson. This image was enhanced by the fact he commuted the mile or so to work in Faulkner's vintage automobile, a convertible something or another from the late 30s, wearing a safari-type outfit which did not vary appreciably with the season. By the 1950s, however, Malcolm had acquired a jeep and was into war surplus camouflage gear. For large and important campus social functions such as the annual law school bash, Malcolm was the designated "rum runner" to Memphis (Mississippi was officially dry at the time). He was a popular guest at these functions and usually passed out in the shank of the evening.

Malcolm is listed as a technician through 1957 so he did make the move to Jackson. He had worked closely with Dr. Nichols and whether it was this loss or something else, the Jackson scene must not have set too well with his psyche. For a time he worked for the physiology department and a few years later wound up with a job at the medical school in Charleston. He succumbed, shortly thereafter, to the effects of demon rum.

In 1955, Martin Ajemian (BA, Boston, 1937; MA,

Ark., 1951; PhD, Georgetown, 1953) was appointed as Associate Professor. He was born in Harpoof, Armenia in 1914. Prior to his arrival at Oxford he had been Professor and Chairman of Anatomy at the Southern College of Optometry in Memphis, and before that, Professor of Biology at Arkansas State College.[17]

Following legislative approval in 1946 of a four year medical school, Dean Pancratz began the monumental task of bringing the proposal to reality. Incidently, the site in Jackson selected for the new Medical Center had formerly been occupied by the old lunatic asylum which had been the primary source for cadavers for the Anatomy Department (Fig. 13). In early 1947 he asked Dr. Hogg to make a survey of the operations and physical plants of anatomy departments across the country and elsewhere. Additionally, Pancratz sent him on a fact-finding mission to some of the more notable departments, particularly those with newer facilities in the mid-west and northeast. Hogg's mission was to find out what was needed for an up to date department. It would have been interesting to see Hogg's expense account for those tours; chances are that it was itemized down to the cup of coffee, and with an unquestionably minimal total. From the mail responses and his on site observations, and ever mindful of budgetary limitations, Dr. Hogg along with other members of the department formulated requisites for a contemporary anatomy department. These projections served as a nucleus around which the architects drew the plans for the new medical center's anatomy department. Although a number of the better financed departments had refrigeration units for cadaver storage, Hogg taking into account the modest State of Mississippi ecomony and the fact that the building was originally planned and constructed without air conditioning, concluded that the traditional vat method of cadaver storage best met the local needs. Further, he determined that the vats should be on the ground level, accessible to outside delivery. Appropriate embalming, preparation, and storage areas were adjacent, as was a special elevator. Nine vats with heavy wooden covers operated by pulleys occupied the major space. The size of the vats was likely designed for about eight bodies each, although frequently they were to contain twice that number. The storage solution of mineral oil and new 30 weight motor oil was adequate except in the cases of overcrowding. Because there was to be no air conditioning, the Anatomy Department was projected for the top floor (7th) of the building, with vast window expanses in the laboratories. The top level also provided some degree of traffic limitation to the general public. The gross lab occupied the whole north end of the 7th floor with partial metal partitions dividing the major



Fig 12. — University of Mississippi Medical Center, Jackson. Photograph Circa 1955.

space into six cubicles, four dissection tables per cubicle, intended for four students per table. There was a separate wash-up room and two prosection rooms adjacent. A lecture room (7A) with a seating capacity of 150 and "state of the art" equipment (a lantern slide projector and a PA system) was next door. The histology area included laboratory space for technical preparation and abundant storage. The lab area was designed in modular units, each to contain 44 students. A folding partition divided two such units for immediate utilization, and an additional module, was provided for class expansion. Dr. Nichols, who opposed the original idea of a combined gross/histo lab was likely responsible for the functional design of the desk/locker combination with an access shelf for slide boxes. The combination was both efficient and asthetically pleasing. Joining the lab modules (to the south) was a large area designated as an anatomical museum. Along the east side of the department was a large space for graduate students, storage, two large faculty research labs, and a huge and completely equipped wood/machine shop. Down from the lecture room (on the west) was the departmental office; the chairman's office with a lab work area; a conference room and a series of four office/lab combinations for faculty, plus three additional rooms or offices of various sizes. Across the hall from the conference room, was a graphics/photography studio complete with a darkroom. These spaces, including the histology lab and museum, reached down to double doors opening into the hospital area (pediatrics to the west and psychiatry to the east).

And so, in early summer of 1955, the migration from Oxford to the big city and a four year medical school was accomplished (Fig. 12). Including Dr. Hogg as Chairman (by now with the awesome salary of $10,000), there were three faculty members in the Department; the

other two were Dr. Ward and Dr. Ajemian. Dr. Tracy was still on board but always listed as an associate.

Ironically, with the new building basically completed and most fixed equipment in place, Dean Pancratz was made aware that no space had been planned for an office for the Department of Psychiatry. He asked his old buddy Hogg for a "temporary" loan of the areas allocated for histology lab expansion, the museum and the conference room. Coincidently, he also "requested" Anatomy Department equipment funds (100%) to alter these areas for psychiatry. Pediatrics, also suddenly developed a need for the three rooms opposite the recently aquired psychiatry office. None of the space, other than the conference room, nor any of the funds were ever restored to the Anatomy Department. Another last minute decision, or afterthought as it were, was to air condition the entire building; consequently, the conduit system was installed, suspended from the ceiling of the hallways with a subsequent lessening of head room.

Dr. Hogg, the prototype of the old school of anatomy before the advent of subspecialities and sub-subspecialities, was equally prepared for teaching in all areas. Concerning research, in his way of thinking, one took for granted that an anatomist would have an inquiring mind and would seek to expand the fundamentals of the field, as well as his own personal knowledge. In the days before research grants were available he had a continuous research program underway and published several significant papers, particularly on the development and fate of the first and second aortic arches. He is credited with the first detailed description of the Edinger-Westphal Nucleus. These observations from serial sections of developing rats. Considering the restraints on his time, Hogg was well informed on current research and the literature, not only in anatomy, but in other fields as well, especially physiology. He used this information to constantly update his own thinking and teaching. For example, he proposed that a momentary, localized vascular accident with accompanying edema, associated with programmed cell death (apoptosis), could well explain many variations and anomalies in development. This conceptual insight was formulated long before research would substantiate it. Such a concept, he believed could have a wide range of application by way of an explanation of an aberrant artery, or the decent of the testes. In the gross lab he was impressive. For example, when asked by a student for help in locating the left superior geniculate artery. Dr. Hogg would do about a two inch wide cut-down and clamp his forceps around the vessel. His accuracy was verified after the student had spent an hour cleaning up the relationships. In embryology, a course he had taken over after Nichol's death, Dr. Hogg was not satisfied with the limitations of the lantern slide projector in the lecture room. His solution was to purchase linen window shades upon which he projected embryo sections with the aid of a camera lucida (in the graphics studio) and copied them in charcoal, fixing the image with a varnish. He had dozens of these window shade "illustrations" of all ages and stages of development and all from the student slide sets. He had holders for these shades mounted on a wooden rail on three sides of the lecture room. The scheduled topic for a lecture dictated the selected hanging of the day, hung around the room in the sequence of the lecture. An interesting bit of color regarding some of these lectures was told by students. Sometimes by the time Dr. Hogg got to the third wall (western) of the lecture room (7A), some hour or so after he had begun, he would lean against the wall and doze off for a few minutes and then resume the "message" at precisely the point where he had left off. The embryo lab was an institution unto itself. This was in the halcyon days when the embryo course had hours equal to histo and neuroanatomy, with two four hour labs per week, in addition to three one hour lectures. As was the tradition at the time, there was an emphasis on the study of a whole, serially sectioned 10mm pig. This was proceeded by some early chicken development and a bit of amphibia. To this base Hogg had added several sagittal sections of human specimens beyond the 10mm stage. Of special merit was the so-called Looper embryo, a 12 day old human specimen, complete with endometial relationships which had been obtained by Dr. Looper back in Oxford. The course was a "challenge" for the students, and Dr. Hogg took few prisoners.

It was indeed a different time; there was an honor system and a dress code. Dr. John Gibson, who was a freshman in 1956 recalls, "being in medical school was considered a real professional situation, and all male students wore suits, and the women wore their nice, Sunday-go-to-meeting dresses. There was a contrast between the look and smell of first year students; in the gross lab we wore white lab coats which soon got stained and emitted odors of formalin. At lunch break, we would hang our white coats up and put our suit coats back on. As we stood in line in the cafeteria, although we looked rather prim and proper, the formalin smell was still with us, and it was easy for others to tell which ones of us were first year medical students. Sometimes, we were invited to go to the head of the line".

Because of age restrictions at the time, Hogg had to step down as chairman in 1958, although he continued on the faculty, full time, for another four years and "kept hours" for an additional year. His lifetime of experience

made him wise council for the younger faculty. In the early 1960s there was move throughout the state supported universities to rotate the chairmanship within a department. Ole Miss adopted this policy on the Oxford campus, and there was a proposal in the medical center faculty senate to extend the policy to the Jackson medical center. The clinical chairmen treated this innovation with great disdain and refused to even consider the proposal. There was a less dramatic but equally negative reaction among the basic science chairmen. The underlying rumor mill had a field day. Hogg's evaluation/response was that, "if people were doing the job that they were being paid to do, then they wouldn't have time for such nonsense".

To me, personally, Dr. Hogg was an awesome presence. In my third year as a graduate student in anatomy (1962-63), I was put in charge of the embryo course. During a rather brilliant lecture on the development of skeletal musculature, and with my brilliance derived primarily from Hamilton, Boyd, and Mossman's text on Human Development, Hogg walked into the back of the lecture room and sat down. I remember well that my face turned a livid red and I stammered through to the end of the period. Dr. Hogg was most considerate and made no comment on my presentation.

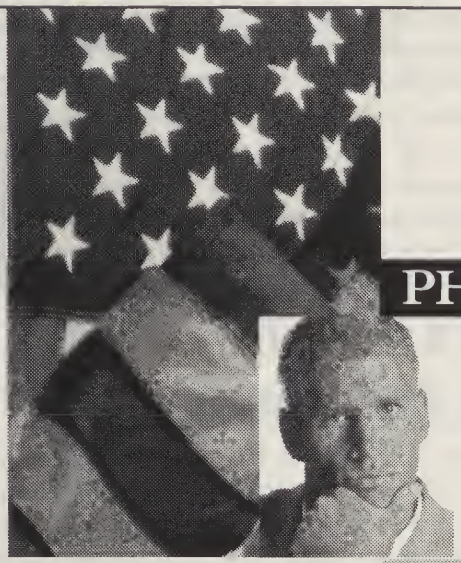
For reasons, possibly both economic and social, Dr. Tracy chose not to set up residence in Jackson, but commuted from Oxford for his scheduled teaching days. His metal cot for sleeping usually occupied the graphics room, or if it was busy, he favored the shop for his quarters. In the early morning hours, in house slippers and with towel in hand, he would make his way to the shower in the morgue area of the basement for the amenities.

When Tracy retired yet again, Dr. Ward took over the neuro course. Ward's neuro lectures were mostly rote declamations. Since the lantern slide projector had no remote control, it was necessary for an individual in the back of the room near the projector to manually change the slides. The common practice for most lecturers was to say, "next slide, please", but Ward had modified this procedure in that when he was ready for the next slide he would lightly tap the screen with the long wooden pointer which he always carried. In one instance, the light tap did not alert, or awaken the operator; neither did the second, more forceful tap. On the third, and even more forceful tap, the operator was finally roused, having been disturbed by the crash of the screen falling to the floor. With some frequency, the lantern slides were accidentally inverted when placed in the projector with a consequent reversal of structures. The fact that the fasciculus gracilis took on a new and more ventral configuration was a "minor" discrepancy to which Ward paid not the slightest attention.

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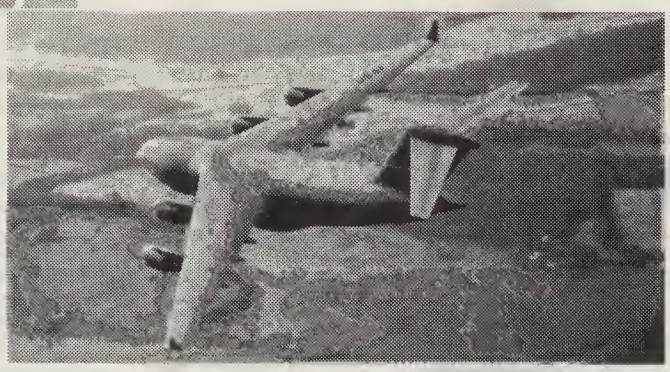
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Sexual Assault: The Physician's Role in Prevention and Treatment

Diane K. Beebe, M.D.

Abstract

Rape is a crime which occurs to over 12 million women.[1] It has a substantial impact on the physical, psychological and social health of the victim. It is defined as the carnal knowledge of a person forcibly and against their will and includes successful and unsuccessful assaults. In this sense, the terms rape and sexual assault are used interchangeably. Physicians should responsibly counsel patients when appropriate concerning prevention of sexual assault and should be knowledgeable about the acute medical and psychological management of a sexual assault victim, including the collection of evidence. This article provides basic information regarding examination, evidence collection and treatment.

Key Words: Sexual Assault, Rape, Evidence Collection

Prevalence

In one quarter last year, Mississippi's Rape Prevention and Crisis Intervention Program reports over 3800 calls statewide to their crisis line with 245 reported sexual assault cases. Barely over one-half of those assaults were reported to law enforcement.[2] These local statistics mirror national estimates which for years have supported the fact that rape is under reported and, therefore, under recognized.[3] Reasons for this under reporting vary. Victims feel shame within themselves and from societal pressure, especially if the assailant is an acquaintance. Stranger rape is often unreported due to lack of proof and a feeling of low probability for legal conviction. Inconvenience of reporting and fear of reprisal by the assailant are also reported factors. In Mississippi, there is no mandatory reporting requirement for adult sexual abuse victims, with the exception of vulnerable adults.

Prevention and Recognition

The physician's role begins with patient awareness and preventive counseling against assault. Since approximately 80% of all rapes involve an acquaintance, safe dating practices, use of alcohol and drugs and sexual responsibility should be discussed with both sexes and at all ages. Sixty-one percent of rapes in one large study occurred before the victim was 18 years old.[1] Adolescent ideas of dating may add to the skewed acceptance of date rape" among this age group, particularly among males. Date rape workshops on college campuses have been shown to increase the awareness that sexual activity without consent is never acceptable.[4] Some adolescents, however, view unstated permission for sexual activity related to the amount of money spent on a date, the level of intoxication of the partner or the tolerance for "heavy petting" and flirtatious activity prior to the assault.[5] The elderly are also at high risk for sexual assault. Many elderly live alone and rely on strangers for transportation, housework, and health care. Because of their often frail physical stature, decreased mobility and strength and possibly dimin-

ished mental acuity, the elderly may be particular prey to perpetrators. Their lack of social and financial resources may further hinder their reporting of the crime.[6] All patients presenting to a primary care physician's office should be screened for a history of violence. Routine questioning in the physician's office is the first step in recognition and treatment for a patient. Patients with an undisclosed sexual assault history may present with low self-esteem, sleep disturbances, eating disorders, self-destructive behaviors and abrupt behavioral changes.[5]

The Physician's Role

Once an assault occurs, evidence collection, medical treatment and patient support are essential. It is not the function of a physician to determine if a rape has occurred. Rape is a legal, not a medical, term and the commitment of the crime is determined by the court. Physicians are obligated to document the history and physical examination of the victim while collecting evidence as permissible by the victim to aid in the courts determination.[7] Patients should be urged to allow evidence collection if less than 72 hours have passed since the assault regardless of their initial decision regarding legal action. After this time period, submissible evidence is unrecoverable, but victims should still seek medical care and psychological counseling. Regardless of legal proceedings, physicians need to treat any physical injuries sustained in the assault and offer treatment for prevention of sexually transmitted diseases and pregnancy.

Acute Management and Evidence Collection

The Mississippi Coalition Against Sexual Assault has developed protocol for forensic and medical examination which addresses community, hospital, physician and victim issues surrounding this crime.[8] In an acute setting, initial management of a sexual assault victim requires calm, compassionate handling of the patient in a quiet, protected environment where questioning and examination can take place. Sexual assault should be designated as an emergency and handled as such. It is important for the physician and the medical staff assisting the victim to be aware that the psychological presentation of the victim can vary from quiet and introverted to hysterical and expressive.[9]

Having well-trained support personnel to provide crisis intervention for the victim in the emergency room is extremely important. This may be provided through the hospital or in conjunction with the Mississippi Rape Crisis Centers. A friend or family member should also be allowed to stay with the victim throughout the examination if requested by the patient. How a patient is treated immediately following a rape significantly influences recovery.

A brief medical history should carefully record information about the alleged assault in the patient's own words when possible and include the information outlined in Table 1. Questioning should be non-judgmental and specific enough to direct the examination. All patients should give consent prior to conducting the medical examination and the collection of evidence. Allowing the patient to give periodic permission to continue with the examination also helps to provide her some control over her situation and can be reassuring.

A thorough physical exam and collection of specimens required for diagnosis and treatment of acute injuries and disease is combined with the collection of evidence. Physicians should familiarize themselves with the contents of a standard rape kit which contains evidence collection materials and instructions. Patients should be encouraged not to change clothes or bath prior to evidence collection. Urination and defecation may also obliterate evidence. Evidence to be collected includes both under and outer clothing worn by the victim at the time of the assault. Clothes may provide foreign matter such as semen, saliva, blood, hair, fibers and debris that are specific to the assailant and the crime scene. Torn clothing may provide evidence of force. To avoid contamination, only the victim should touch her clothes while disrobing on clean examination table paper that might catch falling debris, hair or fibers. If this is not possible, the examiner should handle the clothes only with gloved hands. Each article of clothing should be placed in a separate paper bag after any stains are allowed to air dry. Plastic bags may enhance bacterial growth on clothing or swabs, altering the evidence.

The victim should be examined for evidence of bruising, abrasions, lacerations, and bite marks. Common sites of extragenital trauma in women include the mouth, throat, wrists, arms, breasts, and thighs.[7] Stained areas, particularly those fluoresced with a Wood's lamp indicating semen, should be swabbed with saline-moistened cotton swabs and submitted as evidence. Swab from the area surrounding a bite mark may yield saliva from the assailant. Fingernail scrapings may also yield useful evidence.[8] Combing of the victim's pubic hair may yield material traceable to the assailant, while plucked pubic and head hairs help differentiate the victim's own hairs from those not identifiable to the victim. Fifteen each of the victim's plucked head and pubic hairs must be submitted. Only water should be used during the vaginal examination. Lubricants may interfere with cultures and

Table 1

Medical History

The Assault:
1. date, time, location
2. details of physical contact:
- oral, vaginal, anal intercourse
- penetration, ejaculation, urination
- use of restraints, weapons, drugs, alcohol

The Assailant:
1. single or multiple
2. age, race, stature

The Victim:
1. sexual history:
- last voluntary intercourse, contraceptive use, last menstrual period
- recent infections
2. activities since assault:
- bathing, douching, urination, defecation
- clothing changes

semen evaluation as well as being spermicidal. The condition of the hymen, vaginal walls and cervix is important to document. Two oral, 4 vaginal and 2 slightly moistened rectal swabs should be collected and submitted for evidence of spermatozoa and seminal plasma components. All orifices should be swabbed for completeness since confusion, embarrassment or lack of understanding on the part of the victim may not provide a clear history of the type of sexual contact that occurred. These samples should be sent directly to the crime lab with the other evidence collected. Any attempt to identify sperm at the time of exam could compromise the integrity and quantity of the sample as well as the quality of the results.[8] The recovery time for motile and nonmotile sperm in all body cavities is highly variable in the medical literature, however, motile sperm may be recovered from the vagina for up to 24 hours following ejaculation. Nonmotile sperm may be present in cervicovaginal secretions for approximately 2 weeks.[10] Nonmotile sperm may be recoverable in the rectum and oral cavity at the gumline for several hours.[8] The absence of semen does not preclude sexual assault. Impotence, ejaculatory dysfunction, azospermia or condom use may have occurred. Low sperm counts may be the result of alcohol or drug use. Even without spermatozoa, small traces of semen may yield analysis of various semen-specific glycoproteins, genetic markers and DNA evidence. Cervical and rectal swabs should be taken at the time of examination for gonorrheal and chlamydial cultures and processed as usual through the hospital or clinic laboratory. Vaginal secretions for immediate identification of trichomonas should also be collected. Blood testing for syphilis, Hepatitis B and HIV documents the victim's baseline status and can be compared to follow-up studies. Empiric treatment for gonorrhea and chlamydia is recommended. Treatment for possible Hepatitis and HIV exposure should be discussed with the victim. Hepatitis B immune globulin can be administered in series during follow-up care. A serum beta-HCG is recommended for pregnancy testing followed by counseling on pregnancy prevention measures. Pregnancy prophylaxis must be given within 72 hours to be effective. Treatment recommendations are found in Table 2.[5]

Table 2.

Sexually Transmitted Disease and Pregnancy Prophylaxis

Gonorrhea/Chlamydia	**Ceftriaxone sodium 125-250 mg IM plus dorrycycline 100 mg PO bid X 7 days or azithromycin 1 g PO (non-pregnant women only)**
Syphilis	**none**
Hepatitis B	**Hepatitis B immune globulin - 0.06 ml/kg IM initially with completed series on follow-up care**
Trichomonas	**Metronidazole 2 g PO**
Pregnancy	**Ethinyl estradiol/norgestrel 2 tabs initially repeated in 12 hours**

Psychological Sequelae

An estimated 1.3 million women suffer from rape-related post traumatic stress syndrome.[1] The Rape Trauma Syndrome is described as an acute phase lasting days to weeks immediately following an assault and a reorganization phase lasting months to years. Within the reorganization period, victims go through outward adjustment and personal integration stages prior to reaching recovery.[9] Victims of sexual assault are 3 times more likely to have a depressive episode and 13 times more likely to attempt suicide.[1] Sexual assault survivors are also more likely to experience drug and alcohol dependence, generalized anxiety and obsessive-compulsive disorder. Women with a history of sexual assault report more symptoms of illness across all body systems than non-victimized women. Persisting complaints with a high incidence in sexual assault victims include chronic pelvic pain, gastrointestinal disorders, headaches, psychogenic seizures, and premenstrual syndrome.[11] Care for these women must extend much past the immediate event and the physical injuries. Extensive counseling with rape crisis personnel and other trained professionals may be warranted.

With sexual assault constituting a major crime in society today, physicians need to increase their awareness of the problem, learn to identify and counsel patients affected, and be comfortable with initial patient management, evidence collection and treatment.

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Coding Concepts

Q. We recently agreed to participate in the new Tri-Care programs offered by Champus. However, we are now questioning the payment amount for two procedures involving the eye. Our services included an injection (67025), vitrectomy (67038), and photocoagulation (67228). Champus only paid for the photocoagulation. Can you explain?

A. The reason for the denial or partial payment is part of the bundling edits used by Champus in the Tri-Care program. According to CHAMPUS Policy, (Vol. 1, Section 16.65091.1, Page 65091.1.2), a vitrectomy (67005--67040) is covered when performed as an independent procedure. When this procedure is performed with other procedures, the reimbursement for the vitrectomy is included or bundled in the reimbursement for the other procedure.

This is a specific policy developed for the Champus Tri-Care Program. Had you billed a carrier who followed AMA or HCFA guidelines, you would have received payment for the vitrectomy and photocoagulation. The injection procedure would have been incident to the vitrectomy since it follows the guidelines for separate procedure designated codes - no additional payment. According to Medicare's Relative Value Study, the vitrectomy has an RVU of 49.25 with the photocoagulation having an RVU of 22.26. The vitrectomy would have been the primary service.

Because you have an agreement to provide services to Tri-Care patients, your situation is limited by the established policy of the carrier resulting in a lesser payment. You were correctly paid based on Champus policy.

Q. Recently, I heard somewhere that I do not have to use Modifier -51 on Medicare claims. Can you clarify?

A. Modifier -51 is used to indicate multiple procedures. Not all multiple procedures require the use of this modifier. Based on the description or classification of service, many codes are add-on codes not subject to multiple procedure reduction.

Inappropriate use of Modifier -51 with commercial carriers could result in reductions in reimbursement that should not have occurred. Medicare carriers no longer require the use of this modifier since offices are paid based on the relative value of the service.

A good rule of thumb would be: "If in doubt, leave it out." Insurance companies will pay you according to their policy guidelines allowing you to receive your full entitlement. The only current exception to the rule involves nonparticipating physicians in the Medicare program. For Medicare, when an office does not accept assignment, it is the responsibility of that office to know which codes are subject to multiple procedure reduction since you must bill appropriately or be in violation of the limiting charge factor. You can obtain a copy of modifier indicators from your local Part B carrier. Also, Part B carriers generally update this information in the December or January newsletters.

Q. Do I need to obtain a Waiver of Liability or MUS statement for routine procedures when treating Part B recipients?

According to HCFA rules, when a procedure is routine in nature, you are not required to have a MUS

statement signed. Routine services should only be submitted at the patient's request because of a secondary insurance that will pay for the services not covered by Medicare. When submitting routine services, you need to indicate on the form that billing was submitted because the patient requested the form be filed. This may be indicated in the notes section for electronic filers or on the paper claim.

The MUS statement is only for services which you believe will be denied for medical necessity not for routine services. To illustrate, let's review urinalysis codes 81000 through 81003. When these services are provided as routine screens for preventing medicine or a general health screening, you would not submit the charge to Medicare nor would you be required to have a MUS statement signed since the service is routine in nature. However, if the urinalysis as a diagnostic test needed to determine the cause of a problem or illness and the office believes the service will be denied due to frequency or the nature of presenting problem, you would need to have a Waiver of Liability signed before you could collect from the patient based on the reason for the denial.

CODING TIP

Before signing an agreement with an insurance company, determine the carrier's payment guidelines. Once a contract is signed, the office is bound by policies that could result in substantial losses of revenue.

Do you have a question you would like answered in the Journal? Send your inquires to Wanda L. Adams, CPC, 3280 Lupine Drive, Arnold, MO 63010. Please include your name and phone number should additional information be required.

* CPT codes and descriptions, copyright 1997, American Medical Association

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ABOUT THE AUTHOR

Wanda L. Adams, CPC, *Healthcare Consultant and published author. Founder and past president of the St. Louis Chapter of the AAPC. She currently serves on the National Advisory Board of the AAPC and the Editorial Panel of Code Facts, a Medicode publication.*

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Michael H. Carter, Jr., M.D.

The President's Page

"This Business of Medicine"

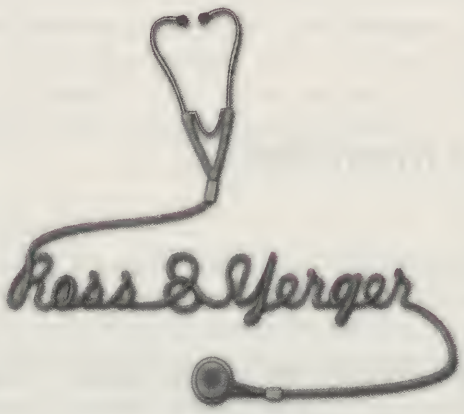
As physicians, our priority is our patients. Because this is a responsibility I take very seriously, I believe we have a duty to do everything we can to make sure that health care reforms initiated by Congress and our State Legislature do not jeopardize health care or sacrifice the sacred doctor-patient relationship.

Protecting that relationship should be a top priority. We must do everything we can to keep that relationship strong and ensure that we can have an open and unrestricted dialogue with our patients about the best options to treat their medical conditions.

Congress spent much of the summer debating the national Patient's Bill of Rights -- an important concept that would hold health care plans accountable for decisions to delay or deny care, prohibit gag clauses, ensure insurance coverage when your patient exhibits symptoms that warrant a trip to the emergency room. The greatest opposition to the Patient's Bill of Rights came from our neighbors and friends -- local members of the U.S. Chamber of Commerce, the National Restaurant Association, the National Retail Federation, the National Business Coalition on Health and the National Federation of Independent Business. They were able to convince many of our Congressmen that health care plans should not be held liable when they preempt the attending physician's advice and make adverse decisions of medical necessity.

Because they speak with a business voice, these national groups get heard in Washington. Their members speak loudly at the local and state level, too. Last year during the legislative session, it was a business coalition of manufacturers and insurance lobbies that tried to kill MSMA's utilization review bill. What many fail to see is that **doctors are employers and doctors are business owners.**

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What they fail to hear is how important medicine is and the tremendous impact the health care industry has on Mississippi's economy.

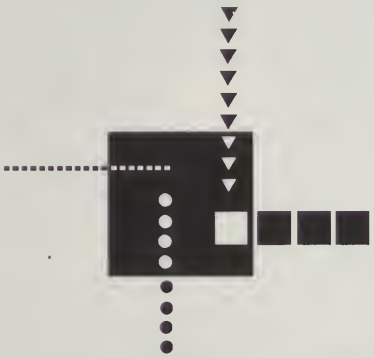
A Vicksburg CPA firm recently released a study showing that a single physician generated more than $1.8 million a year in hospital dollars alone. Further, the total economic impact of a single physician on a community can exceed $4 million a year -based on figures from the Mississippi Center for Policy Planning and Research. This is a business message we must get across to our public officials.

The fundamental impetus for MSMA's -- and AMA's -- political and business activities, then, is the benefit of our patients -- and our members. We cannot leave these important matters to the caprice of uninformed political process or profit-driven policies of third parties.

We must speak in a voice that can be heard. We must speak out in our business voices. We must position physicians as businessmen and businesswomen. We must make it our business.

Mike Carlton

Your Success is Our Goal



American Medical Association Organized Medical Staff Section (AMA-OMSS)* Assembly Meeting

December 3-7, 1998
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- **Improving Patient Care at the End of Life**
- **Key Legislative Issues for the 106th Congress and AMA Advocacy Efforts**

In addition to these educational offerings, as an AMA-OMSS representative of your medical staff, you can participate in policy-making and networking activities. **Our goal is to work with you to identify and address medicine's most pressing issues. We also want to help you increase your knowledge and leadership abilities so that together we can best serve patients, physicians, and the profession.**

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Your success depends on your involvement! Plan today to attend the 1998 Interim AMA-OMSS Assembly Meeting on December 3-7, at the Sheraton Waikiki Hotel. To receive more information and registration materials, please call **800 621-8335 and ask for the Department of Organized Medical Staff Services.**

* The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

** The AMA designates this educational activity for a maximum of 4.5 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

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Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXIX, NUMBER 10
OCTOBER 1998

Notes on the Birth of Garland Dudley Lampton

My second son and child, "boy number two" as my father would say, was born on the afternoon of July 8, 1998, at 4:59. He weighed 7 pounds 5 ounces and was 20.5 inches, a little smaller than his older brother. Needless to say, Daddy and Mommy are proud of the little guy. He came through a rough day with flying colors. I knew he would though, for the Sisters of St. Mary of the Pines of Chatawa were praying for him.

His name is Garland Dudley Lampton, quite a mouthful. This was a tribute to his family heritage. Garland is for my wife's grandfather, Judge Garland Lyell of Jackson, who was a widely known judge in the first part of this century. His claim to fame was his service as first editor of the ***Ole Miss*** yearbook. Not that his editorship was so remarkable, in and of itself, but rather what he did as editor: he held a contest and picked the name "Ole Miss" for his annual, and in later years the annual's name became the nickname of the college.

Dudley is an old Lampton family name. My partner, longtime Magnolia physician Dr. Harry Frye, said Dudley and Lampton were names that naturally went together for him, like peanut butter and jelly. My great grandfather, H. Dudley Lampton, a bank president in Magnolia, was the first in the family to have the name. I admire him for many reasons, but a high point was his courageous and successful struggle to keep his bank open during the Great Depression, and he did this while battling tuberculosis, a disease which would eventually kill him.

I am just as fond of the other Dudley Lamptons: my grandfather, father, and brother, who are three generations of Theodore Dudleys. My father is a physician, well known to many Mississippi physicians from his work at Mississippi Regional Medical Program and later at Student-Employee Health at the University Medical Center, as well as work in the Department of Internal Medicine there.

I hope Garland's name will give him a sense of family, self, and place.

My son Crawford, almost two, seems fascinated with the new arrival, and I feel certain he will enjoy having a younger brother to play with. He already tries to pull him around like a teddy bear, and he calls him "Gar-Gar."

My worst comments about the hospital experience of birth were two nights spent on a hospital fold-out cot. I would have slept more if I had sprawled myself out on the hard tile floor, but each night I tried in vain to contort my body in some fashion that would allow me a sleep cycle. But no luck. My wife would rise and go to the nursery to see Garland, and I would sneak into her hospital bed for a few minutes of shut-eye and rest.

As a physician, I have learned to encourage family members to go home to sleep whenever possible. Certainly, there are times family members are essential at the bedside of a patient. However, being at a hospital with a sick loved one is hard enough, and much worse if you are sleep deprived.

One father of three warned me of the changes additional children make in your life. He said, "It's like basketball. You and your wife have been playing two on one with one child, now you're two on two, a big difference. And if you have a third, you and your wife are going to have to play zone defense, and someone always gets through the zone."

Over the last two years, and especially the last few months since Garland's arrival, the meaning of fatherhood has impacted my life. Perhaps its most significant aspect is the selflessness we are made to experience if we take parenting seriously. In a strange sense, the birth of a child and this ultimate act of creation forces one to submerge much

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.



of one's own agenda. My college teacher Shelby Foote, a lifelong novelist, warned me of such. He is married and has children, but despite this he warned, "No writer should ever get married. It distracts one from the business at hand. Besides the demands of the art, you have the demands of a wife and children to deal with. Not a good thing." Dr. Osler warned physicians similarly to be cautious of marriage and family life, but it is a slippery slope and path humans seldom avoid.

I have now realized that my day at home revolves completely around the young ones. If I want to do any writing or television watching or anything without my two year old hanging all over me, I must do it before he wakes up in the morning, during that brief afternoon nap of his, or at night after he goes to bed. And after a day of play and following the little fellow around, I usually want to go to sleep when he does. Any act of creation with little children around requires an even more creative act to schedule when to do it. But I am reminded of Mark Twain's late life comment, "What is a home without a child?"

What Garland's arrival has reminded me most of all are the lasting bonds of family. I have a little family now like most of you, and when it comes down to it, my family is all that matters. One's job, hobbies, and friends all make life worthwhile. But it is family that is all important. And it never hurts to be reminded of such, even by one so cute and little.

—Lucius M. Lampton, M. D.
Associate Editor

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Dear Dr. England:

In a recent ***Journal of the MSMA*** article, "Screening Colorectal Cancer -- Rational Guidelines", some excellent points were made. There has been a recent change in Medicare reimbursement rules for colorectal screening tests. I am writing this to contribute additional information.

In the past only patients with colorectal symptoms could have a barium examination of the colon covered under Medicare. Beginning January 1, 1998, Medicare began covering screening tests for both average- and high-risk patients. The new coverage includes the following:

AVERAGE RISK Patients (those without any known colorectal cancer risk factors) >/= age 50

- Fecal occult blood testing -- covered annually
- Flexible sigmoidoscopy or double contrast barium enema (DCBE) -covered every 4 yrs.

HIGH RISK Patients (those with a family history [first degree relative, but not an inherited syndrome] of colorectal cancer or a personal history of colorectal polyp or cancer) >/= age 40

- Fecal occult blood testing -- covered annually
- Double contrast barium enema or colonoscopy -- covered every 2 yrs.

Physicians and patients should understand these options and select the best test for each individual circumstance. I believe the double contrast barium enema is an excellent option for many in both patient groups. For average risk individuals the DCBE is the only covered full structural examination of the entire colorectum. For high-risk individuals the DCBE is a safe and cost effective alternative to colonoscopy; in the outpatient setting, DCBE (including the costs of follow-up biopsy with colonoscopy in 10-12 percent of this population) is approximately one-third of the total cost of a colonoscopy examination.

Expert panels convened by both the American Gastroenterological Association and the American Cancer Society have recently reviewed all of these colorectal screening tests. The barium enema has been recommended as an option for average- and high-risk individuals by both groups. The U.S. Preventative Services Task Force also stated that for the detection of lesions > 1 cm (the targeted lesion size for screening studies), the performance of the DCBE and colonoscopy were comparable.

The American College of Radiology estimates that a DCBE every 2-4 years results in less radiation than a standard screening mammogram, and appears to be safer than flexible sigmoidoscopy or colonoscopy.

The DCBE can be ordered in the usual fashion to facilitate Medicare coverage. SPECIAL CERTIFICATION FOR THIS TESTING OPTION IS NOT NECESSARY.

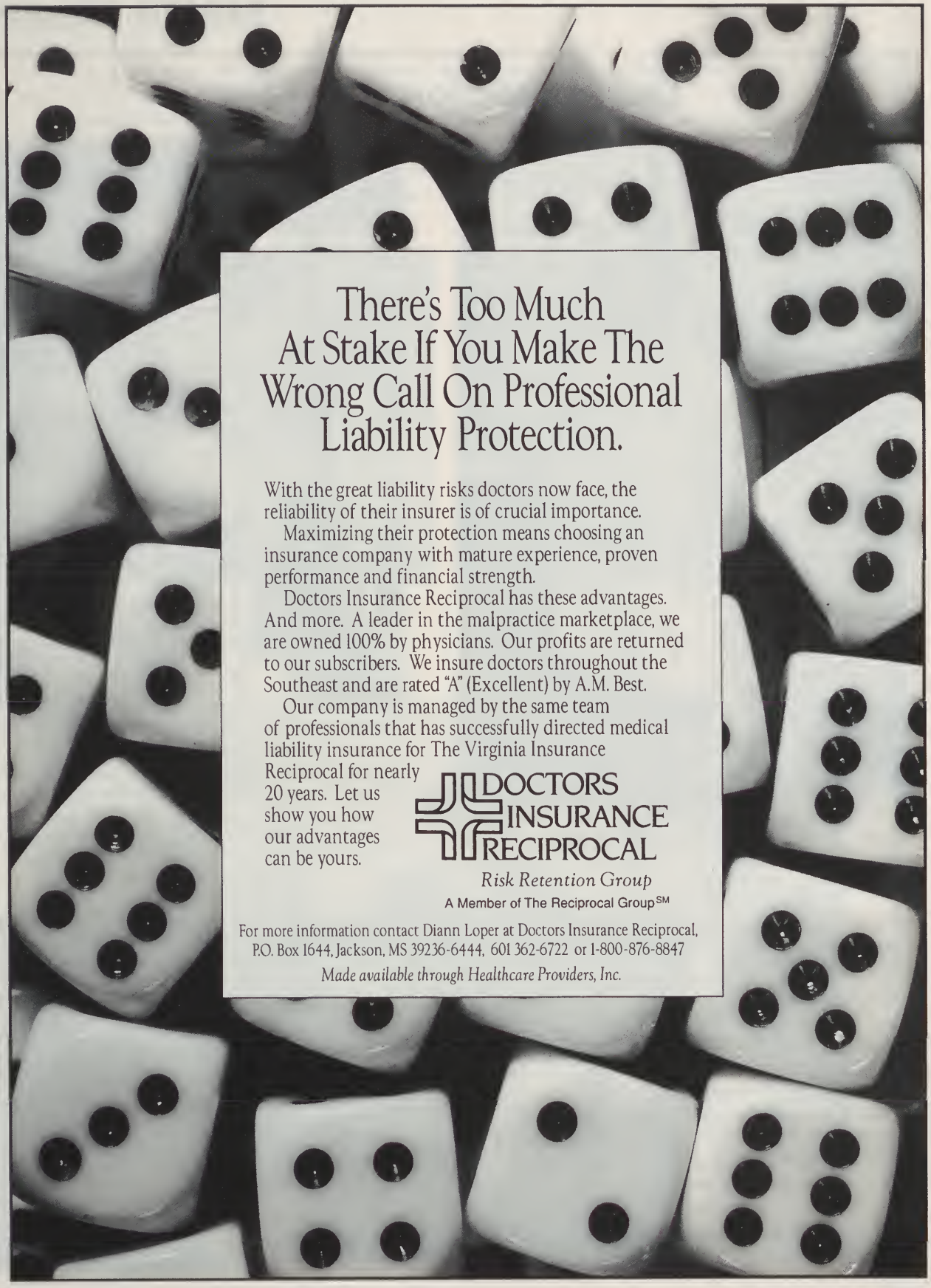
I am, and the entire radiological community is, excited about this new opportunity to bring colorectal screening to our patients. We now know that detection and removal of precursor adenomatous polyps and early cancers will lower the mortality from colorectal cancer. Helping to eliminate this health menace can truly translate into a better life for our patients.

Very truly yours,
James L. Burkhalter, M.D.,
President, Mississippi Radiological Society

Dear —Ed.:

My group, Global Medical Staffing, Ltd., arranges working sabbaticals for doctors overseas in Australia, New Zealand and Canada. GMS works with the governments of these countries to locate carefully screen and provide doctors to their medically under-served communities. The doctors are provided with round-trip airfare, furnished-housing, malpractice insurance, a car and a very modest stipend. The doctors we've placed abroad find practicing overseas to be the adventure of a lifetime both medically and culturally. Many come back and work with us over and over again. We are currently searching for family doctors for six to twelve month positions in smaller farming, mining and retirement towns in Australia and Canada. The ability to function independently and manage uncomplicated obstetrics in strongly preferred. We also need specialists, particularly psychiatrists (adult and child), radiologists, orthopaedic surgeons, internists and anesthesiologists for mid-sized to large cities in Australia and New Zealand. For details, doctors can call us at 1-800-760-3174, e-mail us at doctors@gmedical.com or fax us at (801) 561-9864.

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Early Detection is the Key



Iris Boggan *and* ***Peggy Crawford*** *of East Mississippi Alliance display the 1998 Susan B. Komen Foundation Breast Cancer Awareness scarf. The proceeds from the sale of the scarf will be used for research in breast cancer.*



Glenda Gregory*, Home Economist of Winston County, presents* ***Walter Crawford, M. D.*** *with a pink Breast Cancer Awareness pin and a fact sheet on the disease. At the Mississippi Academy of Family Physicians Annual Session, seventy-five (75) physicians wore the pin in honor of this program.*

The MSMAA and the Extension Service sponsored a Breast Cancer Awareness lecture held a Winona High School for senior girls and five local men's groups. ***Tee Golding*** *of the Lion's Club,* ***Tim McBride*** *of the Rotary Club and* ***Lindsey Robert, Jr.*** *of the Board of Supervisors attended.* ***Peggy Crawford*** *and* ***Kay Emmons****, Extension Home Economist, were the speakers.* ***Nell Middleton*** *organized the event.*



For the past five years, Breast Cancer Awareness has been a major Health Education project for the MSMA Alliance. The goal for this project is the benefit of early detection through Breast Self Exams, yearly visits to the physician, mammograms, and educational releases. The focus for 1997-98 has been on educating high school girls and the male population about this disease, and how they may help to save the life of a loved one because of their knowledge concerning early detection. The Alliance works in coalition on this project with the Mississippi State Medical Association, the Mississippi Academy of Family Physicians, and the Mississippi Extension Service.



***Nancy Bush** explains to **Danita Horne** (left) and **Helen Lauro** (middle) how to use the breast model for explanation to students.*



***Nancy Bush** (left) and **Danita Horne** (right) pin pink ribbons for Breast Cancer Awareness Week.*



*Members of the Lowndes County Health Promotions Planning Committee **Nancy-Jane Skiwski**, (left to right) **Debbie Holland** and **Karoyl McCain** prepare for upcoming programs.*

I. Q. H. Announces New Physician Credentialing/Verification Services

I.Q.H., Information and Quality Healthcare announces its new Physician Credentialing/Verification/ Profile Maintenance Service. Through this new service, I.Q.H. can assist physicians by maintaining a profile and reducing the repetitive credentialing process.

Physicians who belong to one or more health plans, have affiliation/privileges at one or more health care facilities, frequently receive new applications and requests for information from providers, or find it tedious and difficult to maintain current files on required documentation can turn to I.Q.H. for many creative solutions including: review of current provider application(s) for completeness; processing of new and reappointment applications; verification of all primary sources; maintenance of up to date information including renewal reminders for required documents; completion of provider forms; and maintenance of continuing education documentation.

I.Q.H. can assist in verifying all primary sources as well as profiling and maintaining the required information for submission to various providers. I.Q.H. can perform this time-consuming and often dreaded "paper shuffling" task allowing physicians and their staffs to focus on direct patient care areas.

I.Q.H. will not participate in any decisions regard-

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ing membership, participation and/or privileges. All verifications will satisfy standards of the Joint Commission on Accreditation of

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I.Q.H.'s vision is to be a recognized leader in promoting a quality and cost-effective health care system. Looking to the future of health care in Mississippi, I.Q.H. will continue to use its expert staff of physicians, nurses, health information managers, educators, statisticians, data analysts and communication specialists to offer smart solutions to today's health care questions. For more information about I.Q.H.'s credentialing/verification services, contact program specialist Susan McMillan at 1-800-844-0500 or 601-354-0304 in Jackson.

Health Care Quality Improvement Program Update

I.Q.H. staff recently mailed data results about the community-acquired pneumonia project to participating collaborators in the Health Care Quality Improvement Program project which got underway earlier this year. Three hospitals have had data presentations, and other hospitals are sending requests, according to Kathie McAlexander, project manager.

Other projects currently underway include atrial fibrillation, stroke management phase II, the cooperative cardiovascular project, influenza, outpatient diabetes, emergency room acute myocardial infarction, regional stroke prevention education, and the newest effort, the short-term hospital readmission program integrity project. This project includes a comprehensive analysis and evaluation of readmission rates and chart review of clinical performance indicators and utilization practices. Its time frame began this past April and goes through March 31, 1999.

The influenza project which represents one of the earliest HCQIP efforts beginning in 1994-95 has continued to strengthen with the support of physicians and providers throughout the state. Still working toward the challenge of 60 percent of Medicare beneficiaries immunized, the project has resulted in steadily increasing rates of immunization. Physicians are encouraged to remember the importance of October through December for the administration of influenza vaccinations.

For information about any of the projects, please contact I.Q.H. at 601-354-0304.

-James S. McIlwain, M.D.,
I.Q.H. President

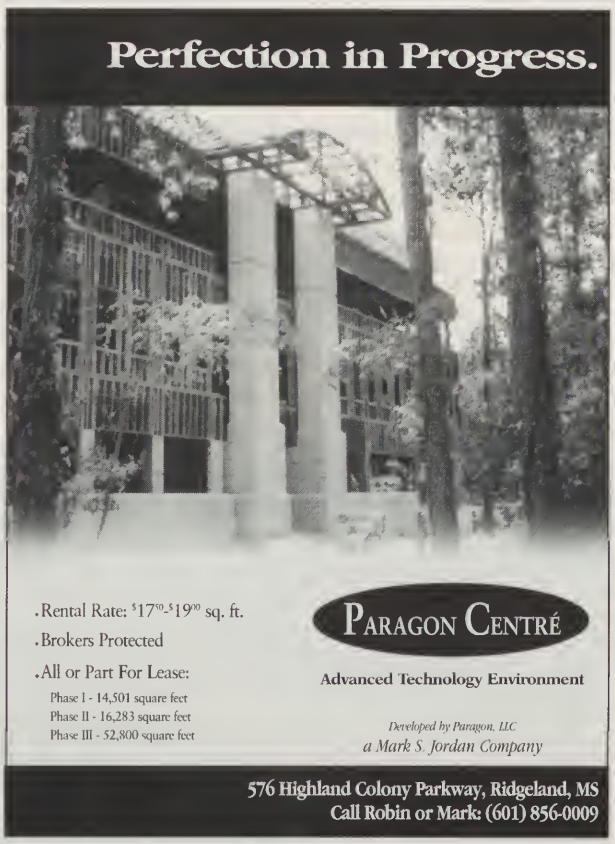
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Annual Health Plan Process Begins

The Mississippi State Department of Health develops a State Health Plan each year under the authority of Section 41-7-173(s) and Section 41-7-185(g), Mississippi Code 1972 Annotated, as amended. The State Health Plan has three purposes: (1) to identify priority health needs in Mississippi;- (2) to recommend ways in which those needs can be met; and (3) to establish criteria and standards for health related activities which require Certificate of Need review. The Department includes public comment from the beginning of the development process through final adoption of the revised Plan.

The process begins each fall with a public forum generally held before the State Board of Health at the Board's October meeting. At this forum, any concerned individual has an opportunity to make suggestions regarding any aspect of the Plan or propose changes to Certificate of Need (CON) criteria and standards. Anyone unable to attend the forum may submit written comments by mail. Staff of the Division of Health Planning and Resource Development study the comments and develop recommendations for any needed changes in CON criteria and standards.

Each January, staff requests the Board of Health to approve an "intent to adopt" the proposed revisions and files the proposal with the Secretary of State. This action initiates a 30-day public comment period in accordance with Mississippi's Administrative Procedures Act.

The Department publishes proposed changes in a statewide newspaper, *The Clarion-Ledger*, mails a copy of all proposed changes to an established list of interested parties, and publishes the proposed changes in a monthly Department newsletter sent to more than 1,000 health care facilities, individuals, and organizations. The Department also provides the proposed changes to anyone who requests a copy.

Staff analyzes any comments received and incorporates them into proposed changes wherever possible. Staff presents final recommendations to the Board of Health at the April Board meeting each year. The Board approves or disapproves each proposed change and issues a "final adoption" of the revised Plan. The Department files the Plan as adopted with the Secretary of State.

Staff also obtains up to date statistical and general information from numerous departments of the MSDH, other state agencies, professional associations, and relevant organizations regarding every topic covered in the Plan. Staff compiles this information and produces a final Plan. Following approval by the Governor, the revised Plan becomes effective July 1 of each year.

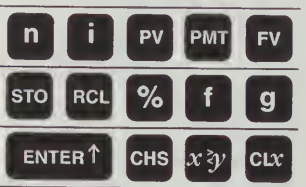
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MSMA Board to Develop Professional Standards to Address Scope of Practice Infringements

By clarifying professional standards for physicians in collaborative practice arrangements with non-physicians, the MSMA Board of Trustees hopes to address the nagging problem of scope-of- practice infringements. "Doctors nced to have clear guidelines as to what treatments and procedures are appropriate to delegate to non-physicians by means of a protocol," MSMA President Dr. Michael H. Carter, Jr. said.



Scope-of-practice was only one of numerous agenda items tackled by the association's Board of Trustees at its summer meeting August 22-23. The Board received information on actions taken to implement fourteen resolutions adopted by the House of Delegates and took the following actions on five resolutions referred for decision or study.

• Adopted an action plan for addressing the problem of nonphysician "scope-of-practice'' expansions, including the development of proposed professional standards governing the conduct of physicians supervising non-physician health personnel.

• Suspended the association's Awards for Excellence in Medical Reporting program for an indefinite period so that resources devoted to that activity can bc used to train additional physician "spokespersons."

• Authorized a task force to study the prevalence and impact of physicians adding a "markup" or surcharge to scrvices provided by an outside laboratory.

• Directed the association's staff to prepare reports for the 1999 Annual Session on "any willing provider" and "point-of-service" requirements, and the pros and cons of requiring all health insurance plans to provide a basic package of health benefits.

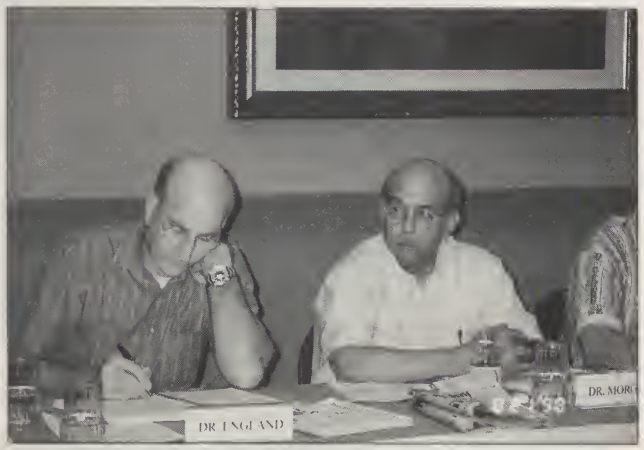
In addition to the MSMA Board of Trustees, the Board of Directors of Mississippi Physicians Insurance Company also conducted its quarterly meeting, and annual stockholders meetings were held for MSMA Diversified Services, the MSMA Foundation, the Mississippi Physicians Care Network, and the Mississippi Physicians Health Network.



MSMA President-Elect ***W. Briggs Hopson, M.D.;*** *MSMA President* ***Michael H. Carter, Jr., M.D.;*** *Chairman* ***Chester R. Masterson, M.D.*** *and MSMA Executive Director* ***William F. Roberts.***



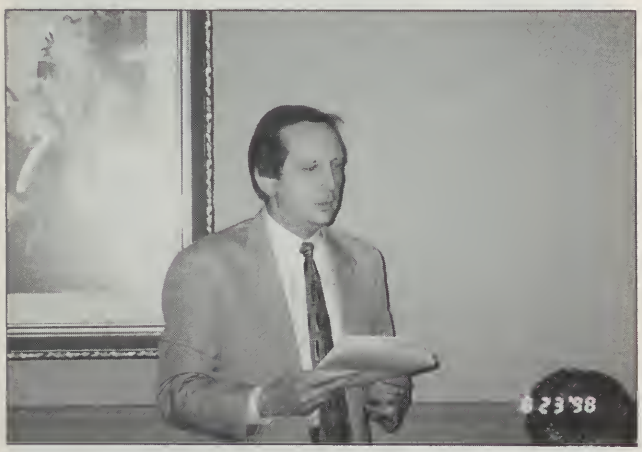
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Newly elected Editor of the JOURNAL MSMA ***Leslie E. England, M.D.*** *(left) attended his first Board of Trustees meeting. Also from Natchez, AMA Delegate* ***Mal G. Morgan, M.D.***



Chair of the AMA Delegates ***James C. Waites, M.D.*** *(left) discusses the capitalization of Physicians Care Insurance Company (PCIC). Seated are (left to right) PCIC President* ***Fred L. McMillan, M.D.; D****elegate to the AMA* ***Nancy O. Tatum, M.D.;*** *SecretaryTreasurer* ***Helen R. Turner, M.D.;*** *and MSMA Past-President* ***H. Vann Craig.***



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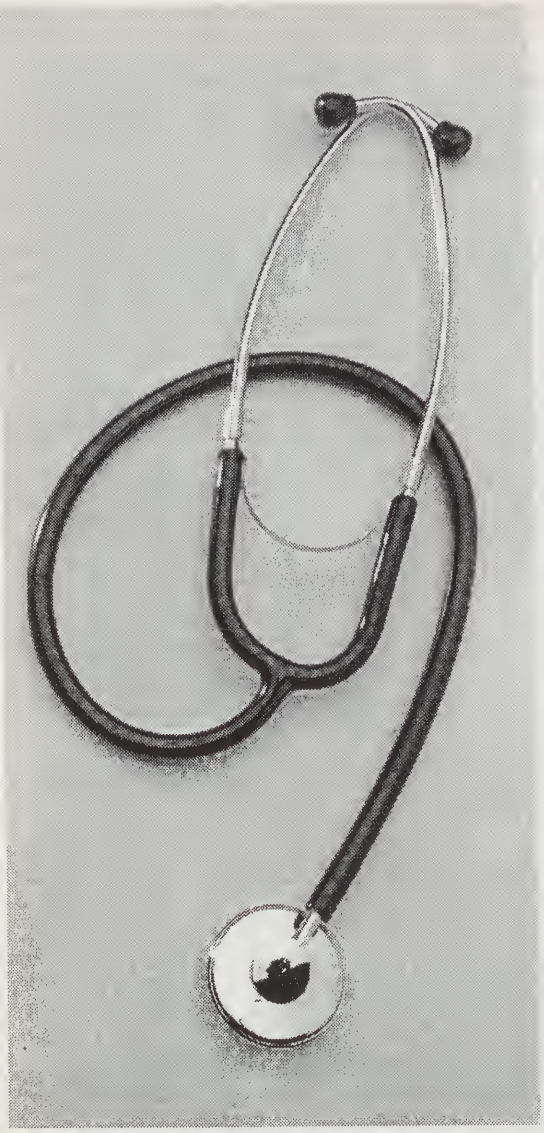
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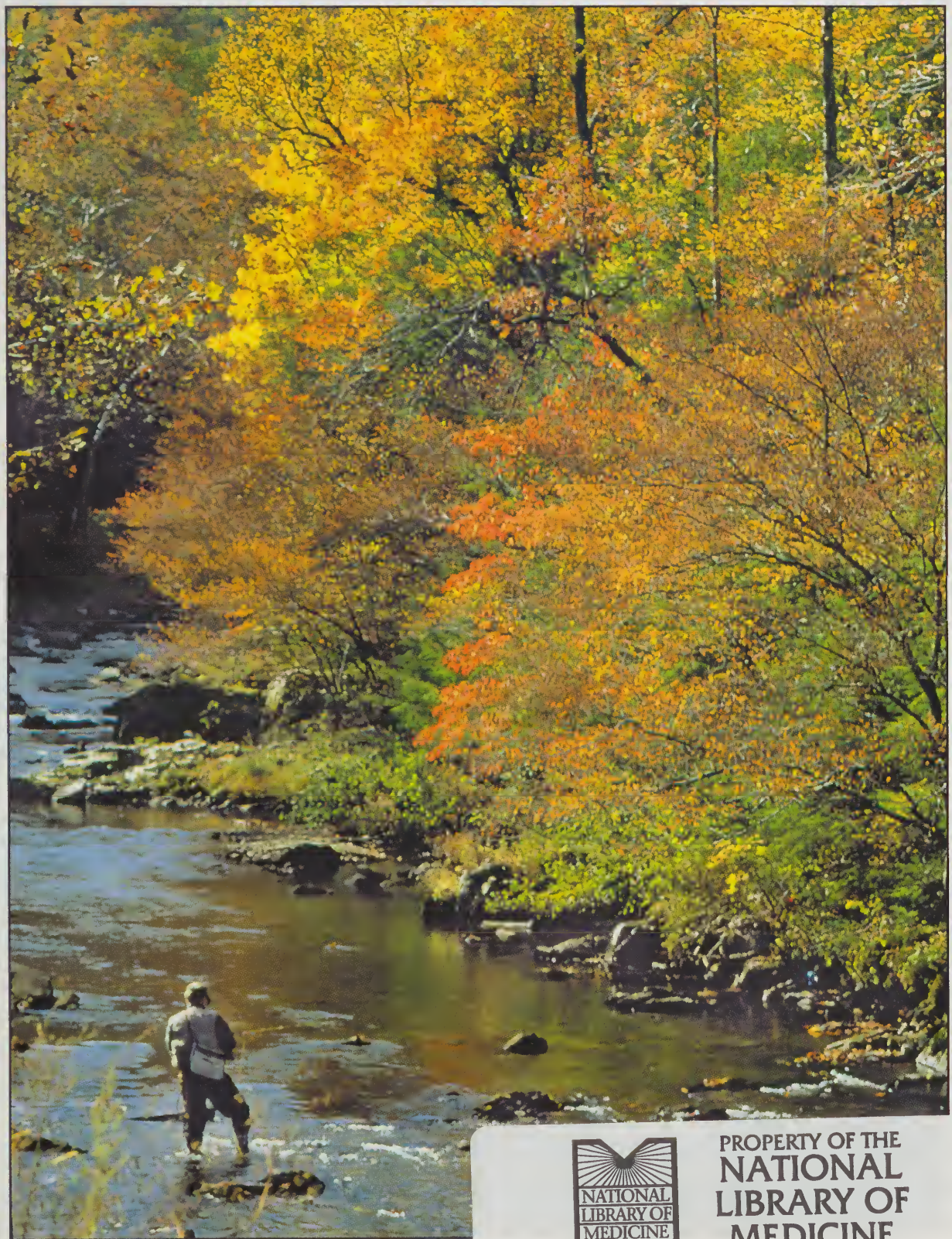
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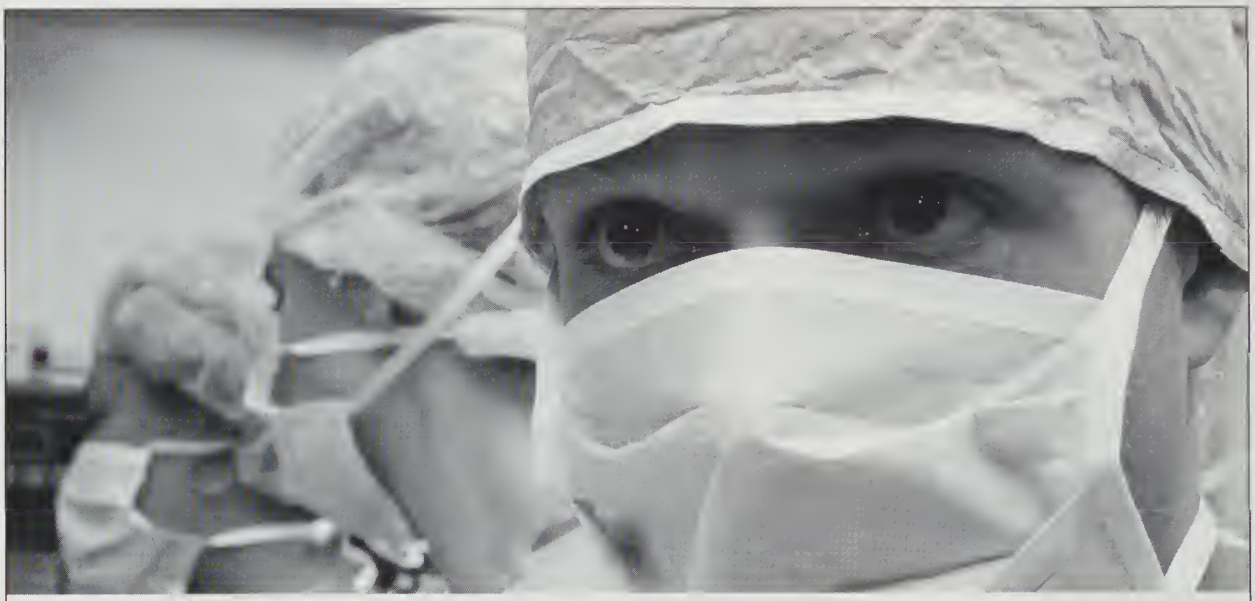
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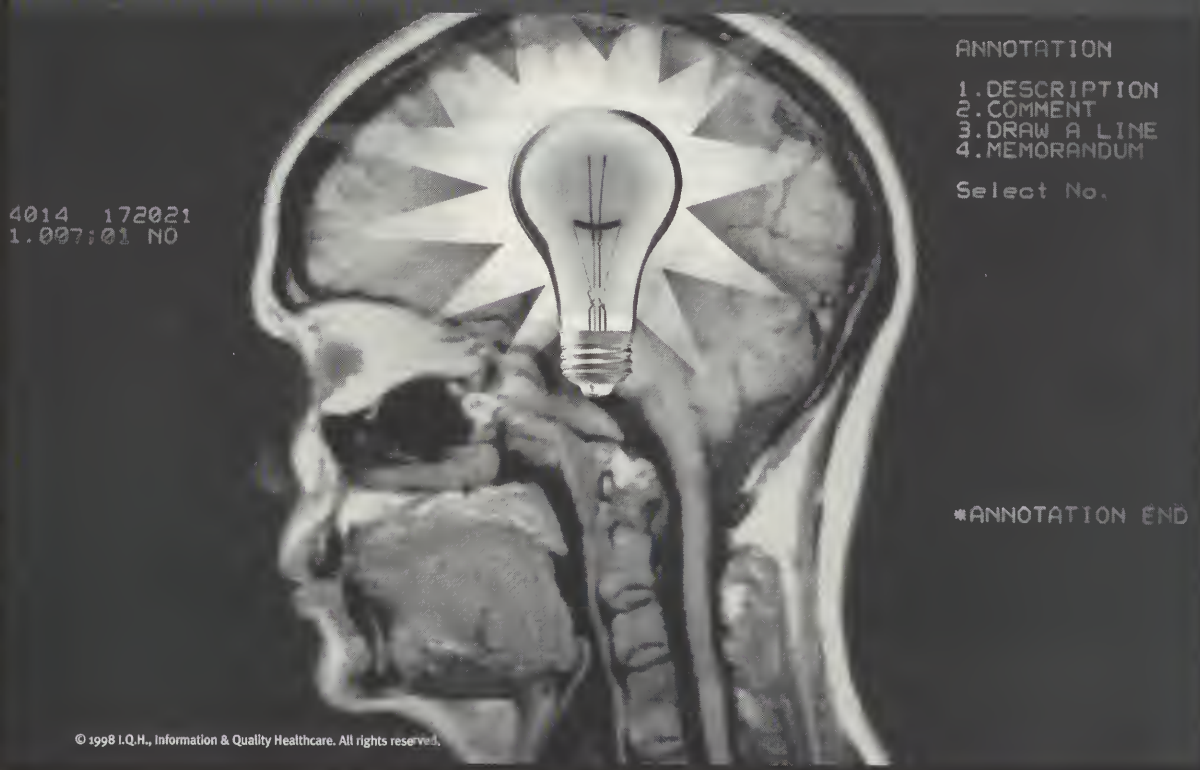
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The Anatomy Department of The University of Mississippi Medical Center A Short, Anecdotal History

Carroll R. Ball, Ph.D.

This is the second of a two-part article. Part 1 appeared in the October issue of the ***JOURNAL MSMA.*** —Ed.

PART IV - POSTPARTUM

And so it came to pass that, like Moses, Dr. Hogg did not get to see much of the promised land. He reached age 65 in 1957, and as required by state law, had to relinquish the chairmanship.

Several individuals of diverse backgrounds and experience were interviewed for the position. The successful candidate was William Lane Williams (BA, Wofford, 1931; MS, Duke, 1939; Ph.D., Yale, 1941), a native of South Carolina (Fig. 14). The newly designated chairman was one who had declined to continue the interrelated course/block system of Dr. Hogg. At Yale he had studied with Edgar Allen in the rapidly evolving field of endocrinology. Dr. Allen had been the first to identify estrogen and established its role in female reproductive physiology. Williams' dissertation related to the endocrine control of post-lactating mammary glands, utilizing vital-staining techniques recently developed by Ross Harrison, a premier histochemist also on the Yale faculty. After receiving his Ph.D., Williams was a member of the Anatomy Department of the University of Rochester for one year, then returned to Yale as an instructor for two years. There followed two years in the Anatomy Department at LSU and then thirteen years with the Anatomy Department of the University of Minnesota School of Medicine. During his tenure at Minnesota, his experience in histochemistry, particularly vital staining, and his two publications in that area (one dealing with the kidney and one with the liver), attracted the attention of the Chairman of Medicine, Dr. Watson. Watson was director of a large Army study project on hepatitis and its relationship(s) to the armed forces and asked Williams to contribute. Williams' work on this project dealt primarily with the fibrous elements of the liver, and ultimately led to studies of the effects of variable dietary factors on liver pathology.

Dr. Williams assumed the chairmanship of anatomy at the School of Medicine in October of the 1958-59 session. In the departmental reorganization which followed, he and Ward took over the courses in histology and neuroanatomy, Ajemian and Hogg were responsible for the gross course, and Dr. Hogg alone taught the course in embryology. There were no assistants.

Williams first major effort on becoming chairman was to apply for an anatomy training grant for Mississippi; he had had experience in obtaining such a grant at Minnesota. The anatomy training grants were a part of the dramatic reaction to the startling news on October 4, 1957 that the Russians had launched the interplanetary satellite, Sputnik. It was not only the first of its kind in



Fig 14. — W. Lane Williams, PH.D. Photograph Circa 1961.

space exploration, but testimony to how far advanced Russian technology was in general. In the euphoria which had followed the spectacular military victories of WW II, the United States had radically reduced scientific research funding, and now was suddenly jolted into a crucial catch-up situation. Congress at the urging of President Eisenhower made huge appropriations to the identified needs of colleges, universities and research institutions. One of the areas which received attention was medicine. There was a shortage of practicing MDs, and an even more acute shortage of teachers in the basic medical sciences, including anatomy. One specific response was to establish the anatomy training programs. The purpose was to initiate and enhance appropriate research and to train individuals to do the research.

Mississippi's applications for an anatomy training grant was approved and funded for a sizeable sum of money (or at least for the time it was). It was activated on July 1, 1960. Carroll R. Ball was the first trainee accepted into the program, closely followed by Allen D. (Bucky) Ashburn and Edward Mayberry. Both Ball and Ashburn had Master of Science degrees in Biology; each had had military service, as well as teaching experience. They became sort of 1st lieutenants for the training program, and when they received their Ph.D. degrees, three and four years later, became faculty advisors to newly recruited graduate students, thus multiplying, exponentially, the entire program. Additionally, the trainees provided critically needed laboratory assistants for the various anatomy courses of the department. Departmental research was channeled into three primary categories: (1). dietary affects on fatty livers which led in turn to observations of diet-induced lesions of the cardiovascular system (Ball); (2). the affects of several steroids on livers and hearts (Ashburn); (3). a less productive thrust concerning pre- and postpartum changes in mammary glands (Mayberry).

Two sizeable animal rooms in the center of the department were established (known affectionly as Mouse Houses I and II) for the care and maintenance of hundreds of inbred and hybrid strains of mice. The overwhelming number of experimental animals, supported by adequate controls, assured the validity of data obtained in the various studies. During the winter months, or while regular classes were in session, individual researchers personally cared for the animals, doing everything from cleaning cages to preparing and feeding of diets, or whatever procedures were called for. A full time histotechnician assisted in the enormous amount of histochemistry required. During the three summer months, medical students were employed to assist at all levels, and the research tempo increased accordingly. These students were from the top of the class academically, and it was considered status recognition to work for the Anatomy Department. Many of these medical students worked for several summers and at least two after they had received their MDs. It was a bit of inside humor that the quality of the research program was evidenced by using MDs for the washing of mouse cages. A number of the summer "helpers" co-authored publications and presented papers at local and national scientific meetings. In total, some sixty five graduate students at the Masters and Ph.D. levels participated in the training program. Twenty nine received masters degrees; thirty received the Ph.D.[14] In 1963, a research wing was added to the north of the original building. Space on the 7th floor of this wing doubled the size of the department, especially in research related areas.

Dr. Williams was a bachelor with quarters at the King Edward hotel. The Hotel was also home to many state government leaders, particularly during legislative sessions. Social contacts made here were of considerable value to the Anatomy Department, and the medical center in general. Williams, impeccably groomed, commuted to the medical center in a magnificent Oldsmobile Toronado. He set a rigorous pace for the departmental work place,

spending long hours in his office, frequently late into the evening. For graduate students with a welter of experimental animals to care for, in addition to class and library research, a 12 to 15 hour day, seven days per week, was the norm. Williams was always available for advice and consultation relative to any aspect of individual research progress. One of his greatest attributes was his editorial prowess. By waving a pencil over a yellow legal pad, he could change rough, lengthy and ambiguous material into a succinct masterpiece. It was uncanny! As an associate editor of the Anatomical Record, he contributed significantly to the quality of the current literature.

Students, both graduate and medical, were for Dr. Williams an extended family, and he projected a parental, benevolent and personal concern for his progeny. Regularly, at eleven a.m. each week day, he invited Ashburn, Ball and Mayberry to accompany him to lunch at Le Fleur's restaurant. Lab coats were exchanged for street coats and ties, and off the four went like the Peabody ducks. Always the same table and same waitress, if possible. Conversational topics covered a wide range from current events to art and literature; the work place was not one of them.

At least one publication in a national journal was a requirement for the Ph.D. degree at the Medical Center. No one in the Anatomy Department ever had a problem with that requirement; in fact, most had several publications when they approached graduation. Additionally, all anatomy graduate students were required to present papers at professional meetings such as the Southern Association of Anatomists, and particularly the American Association of Anatomists. These presentations were carefully scripted with professionally prepared visual aids. All were thoroughly rehearsed under the critical supervision of Williams in order to insure highly polished results. The number of publications from the department, and the level of participation at national meetings was impressive and was the envy of most anatomy departments across the country, far exceeding the output of most.

In April of 1962 the annual meeting of the American Association of Anatomists was held in Minneapolis. Since the Anatomy Department of the University of Minnesota School of Medicine had been the scene of his most recent position, Williams looked forward to displaying his dynamic new department. Four of the more senior graduate students (Ashburn, Ball, Mayberry and Dwayne Rorie) and a third year medical student (C.G. Hull) on a years research leave, were scheduled to present papers. This was the heyday of the popular Panama Limited pullman train of the I.C.Railroad. It originated in New Orleans, stopped in Jackson at 7:30 p.m., and arrived in Chicago some fourteen hours later. The typical two person parlor units could be combined for four people, as a suite. Ashburn, Ball, Mayberry and Rorie were thus accommodated. C.G. occupied a single sleeping unit, so compact that when the bed was lowered, one had to practically stand in the passage way to use the wash basin. Dr. Williams, perhaps by design, was in a different car. In anticipation of a long night, the group had boarded the train with back up supplies such as a large bag of crushed ice, and what was believed to be (but later found not to be) an adequate stock of spirits. The festivities were well underway by Canton and by Memphis, were in "high" gear. The porter, a fine example of his honorable calling, had seen it all before and was long suffering, even when after midnight, the rest of the car complained bitterly of the raucous behavior. He was even tolerant when poor C.G., a novice, got sick and with his underwear clad behind extending out into the corridor, unloaded his misery into the cup sink. A subdued group, grateful for whatever fixed object was near at hand for support, made the breakfast call the next morning. They were able to unload at the Michigan Avenue station, and somehow make it across town to Union Station to board the Burlington line for Minneapolis. The details of this leg of the trip were never very clearly recalled.

Arriving at the Leamington Hotel, convention headquarters, in Minneapolis, the stout hearted band was confronted with a mix up in room reservations. Probably with no alternative, the desk clerk came up with an inspired solution. For the same prearranged price for each, the penthouse, called the Shah's Suite, complete with drawing room, two large bedrooms, three baths and a wet bar, would be substituted. Mayberry and Rorie presented their papers the following morning and then in the afternoon went out to explore the university campus. Among the findings were a couple of comely med-techs who shared an apartment with three other young ladies. Apparently, without too much hesitation the five young ladies accepted an invitation to "party" that evening in the Shah's Suite. One of the group had a portable record player and a bunch of dance records; the popular dance fad at the time was the Twist. Some of the more conservative troops had already gone to bed when the "party" arrived, only to be routed out, and in the vernacular of one of the dance pieces, it was "twisting the night away". Ashburn and Ball had papers to present at eight o'clock the next morning, and with about an hours sleep and a brisk walk outside in the falling snow, they, albeit like zombies, performed. No small testimony to the merits of the time spent in rehearsal back in Jackson.

By this time of the meeting, Dr. Williams, rather than proudly introducing his flock, was going to considerable lengths to disassociate himself from the group, indeed, avoiding them completely whenever possible. The troops, subdued from the rigors of the "meeting" went into a recovery phase on the long train rides home. The constant swaying motion of the trains still being felt days after arrival back in Jackson. What came to be known as the great Minneapolis caper went into history.

For all of his idiosyncracies, Williams demonstrated the essence of a successful administrator in that he delegated all responsibilities for teaching as well as most departmental duties, to others, while relinquishing no authority whatsoever. This was extended to subtle and indirect criticism of details which he found questionable, but commendation for work well done was not in his persona. The closest he is known to have come to complimenting his staff was once during a site visit for a major grant application when one of the visitors raised the question of inbreeding in the departmental faculty. Williams took umbrage at the would be criticism and replied, matter of factly, that when there was a staff vacancy in his department, he sought the very best qualified individuals available, and if, by coincidence, the best was in his department, he saw no reason to discriminate against them. He pushed his graduate students to get their degree requirements out of the way as soon as possible, and then to go for the Nobel if they were so inclined. He constantly pressured the dean for salary increases for the anatomy staff to bring them at least up to Southeastern regional levels. In this effort he was successful in all ranks except that of professor. Early in his chairmanship, faculty tenure was so little recognized at the Medical Center that few, including the administration, even understood how it was to be obtained. Williams undertook the clarification of this critical academic insurance as a personal crusade, and in anatomy, by the rediscovered regulation book, faculty members were granted tenure as soon as they were eligible.

On college and university campuses all over the country there emerged in the 1960s the hippies and flower children, rebelling against the perceived status quo. This tide of release or "freedom" as they liked to call it, moved rapidly to the medical school, displacing traditional discipline, dress and behavior. Long hair, carefully scuffed clothing and pierced body parts, if not the norm, were omnipresent. Formerly unquestioned respect for faculty changed to confrontation, while the honor code, noble vestige of another era, became a farce, faltered, and finally was discarded altogether. Many were the stories of applicants who came for their interviews desperately trying to present an image of conventional respectability. At least one young man resorted to a cheap wig in an attempt to hide (and save) his long hair.

Enrollment of freshmen medical students steadily increased, stressing facilities and faculties. During the era of the capitation grants (1974-82) when federal monies paid a "head" price of $5,000 or more for each student, to encourage training of more MDs, the size of the entering medical class reached 150. While the applicant pool rose quantitatively, largely because the space-age technology market was glutted, the quality of the applicants did not, and since the head money was given literally on number of students enrolled, the administration went to considerable efforts to "retain" as many students as possible. The end result was a subtle and unacknowledged lowering of standards. Lecture rooms and labs designed for a maximum of 80 students could not stand the pressure. The cubicle walls came down in the gross lab. An area taken from adjacent research space was added to the histology lab for seating some twenty students. All wall and window units designed for display and demonstration were pressed into service. Frequently, there were as many as ten graduate students in addition to the 150 medical students. Anatomy's lecture room, 7A, even with desks and chairs around the perimeter, was not big enough. Histology lectures were presented for a time in the ill-suited nursing auditorium. Then, in desperation, the class was divided into two sections with a duplication of lectures as well as labs. The faculty course load obviously doubled. Additionally the Anatomy Department was "called upon" to provide courses for nurses, medical records and allied health; then the dental school was added.

During the 1960's, social security death benefits were extended to cover indigents, granting more that $200 per individual for burial. The State Mental Hospital at Whitfield, successor after 1935 to the insane asylum at Jackson (Fig. 13), utilized these benefits to its financial advantage. Consequently, the supply of cadavers to the medical school was reduced almost to zero. The shortage was so acute that the department had to go out of state for dissection material just to meet its minimum needs. In 1970, responding to this crisis, as well as the rapidly developing needs for organ donors, the Anatomical Gift Act (Law) was passed by the Mississippi legislature.[12] This Act, patterned after national guidelines, provided legal authorization for the donation of one's body or specified organs, to a State Board of Health approved/authorized institution. The public relations department was made responsible for the donor program. There was limited response to medical center-generated information



Fig 13. — Mississippi State Insane Hospital, 1855-1935, Jackson. Sketch Circa 1860.

concerning this program from doctors and medical facilities. The general public, enmeshed in Bible-belt traditions, was slow to react or to take advantage of the perceived radical new concept. The need for out of state procurement not only continued but accelerated.

The department, always operating with a minimal number of staff was further pressured with the steady increase in the number of students. Williams seemed uncomfortable in the roll of formal lecturing, rationalizing that "you couldn't improve on the text books". Ball, was made an Instructor while still a graduate student, and put in charge of the embryology course which fortunately no longer had the oppressive number of lab hours which it had had under Dr. Hogg. When Ball received the Ph.D. In 1963, he became the course director in histology, in addition to his duties as course director of embryology.

Dr. Ajemian was course director of gross anatomy, a position he held until 1974. He knew his gross, but with his "no hands on" practice with regard to the cadavers, he sometimes did not communicate too well with the students. He had a memorable demonstration relating to the rotation of the developing gut. The props included his arms, his lab coat, and a cellophane dry cleaners bag. It was entertaining to watch, but succeeded only in adding confusion to an otherwise relatively simple phenomena. Ashburn was assigned as an assistant in gross anatomy, and when Dr. Ajemian retired (1974) was made course director.

Dr. Ward was course director of neuroanatomy. One great story deals with Ward and his course assistant, Bennie Clower. The two were in the gross lab readying brains for the neuro lab. Dr. Ward did not consider that formaldehyde (concentrated at 40%) should be diluted, so the full strength solution was being used to "fix" the brains. The fumes were terrible; so bad that an osculating fan had been set on top of a nearby cabinet door. Just as the task got well underway, Clower bumped into the door dislodging the fan which, in falling, struck Ward on the forehead, leaving a big bleeding gash, and then proceeded to splash into one of the fluid filled containers. In the ensuing excitement, Clower grabbed a formaldehyde-soaked cloth from the container and attempted to swab off the open wound on Ward's head. This ministration illicited a great outcry of pain from Ward, appropriate language, and a hasty retreat to the wash room. Presumably, workman's compensation was never applied for, nor was there a noticeable change in the pitch of Bennie's voice.

Another episode relating to Ward was initiated by two of the more senior graduate students, namely Mayberry and Ball, and was perpetrated on a first year graduate student named May. This was in 1962 when all

graduate students had a desk in the former conference room now referred to as the "bull pen". May who was taking the neuro course at the time, returned from a lecture dealing with basic neural pathways and walked in on what appeared to be a profound discussion between Mayberry and Ball relating to pathways. May was asked if the auricular-penial tract, (a reflex elicited by blowing in an individuals ear with consequent penial reaction,) had been covered in the lecture. May said that it had not been, did a quick check in the neuro text where he found nothing, and allowed as he didn't believe there was any such pathway. He was curious enough, however, to check with Dr. Ward concerning same, and so he did. Dr. Ward, scratching his head, allowed as, yes, he had heard of such a pathway, but could not immediately recall a source of reference. For some reason, or another, Mr. May never felt comfortable in the bull pen after that.

Dr. Ward was extremely popular at Anatomy Association meetings as he always came well stocked with Jack Daniel's Blacklabel. In 1970, as retirement at age 65 drew near the stress took its toll. Ward became deeply depressed and aged significantly. Then, almost from out of the blue, the newly created South Florida Medical School in Tampa hired him as chairman to organize its Anatomy department. There was a remarkable turn around in Ward's demeanor and he retired from UMC with a big grin on a face which looked at least twenty years younger.

Bennie Clower who had been an assistant to Dr. Ward in neuroanatomy, took over as director when Dr. Ward retired. Each departmental annual report ended with a plea for additional staff, the faculty course load ratio far exceeding any other department in the medical school .[13] With sheer desperation and frustration, Dr. Williams slowly began to add additional faculty. Individuals were recruited on their merits, and the reputation of the institutions at which they had received their training. First priority was given to specific teaching potential, secondly, to their research potential, no matter what the area of interest. A notable example of the "new blood" was Dr. Erwin W. Powell who with an active research program related to the nervous system added considerable stature to the neuroanatomy course. Additional positions made available through the newly created dental school added to the teaching pool. When the capitation grants ended, the medical class was gradually reduced in size, thus the individual teaching responsibilities could be lessened and more time permitted for research.

In addition to the training grant, most faculty members received research funding from intramural institutional grants, as well as such outside sources as the Mississippi Heart Association . All of this funding made for a steady increase in research output and was directed toward major NIH grant applications particularly by Ashburn and Ball. This evolutionary strategy was right on schedule, but alas, the urgency for funding research began to falter with the federal budgetary crunch. This trend and consequent reversal of policy was best expressed in the classic and all too frequent response to a grant application, "grant approved, no funds available". The notification in 1970 that the departmental training grant would not be renewed continued this downward trend. Without federal support, departmental research activities slowed and then came to an abrupt and almost complete halt. Once busy animal quarters, laboratories and equipment sat unused and then evaporated. Hired help suddenly disappeared.

After 1970 the reduction and/or loss of major grant funding became an extremely sensitive issue as it began to be reflected in the annual reports.[13] This was looked on with disfavor by an administration obsessed with grant overhead monies. In a maneuver to off set this turn of directions, Dr. Ben Douglas, a local Ph.D. in physiology, with a research appointment in the Department of Medicine, was added to the anatomy faculty as an associate professor. Just incidently, Dr. Douglas had a very large research grant with many approved years left to go.

The severe reversal in the dynamic thrust of the Department affected Dr. Williams significantly, bringing on depression, withdrawal, and various regimens of compensatory medication. During several extended bouts of this nature, Ball was named acting chairman (Fig. 15). A panacea for Dr. Williams appeared in 1970 with his timely selection as Chairman of the Graduate Council. This important duty was in addition to his departmental chairmanship. The duties of the new position were expanded in 1975 and the title changed to Assistant Vice Chancellor for Graduate Affairs. Williams remained in charge of the graduate program until July 1, 1980, some months after being deposed an anatomy chairman. In 1979, he had reached the mandatory retirement age.

The search committee to replace Williams was chaired by Dr. Armin Haerer of Neurology. The committee was informed from various sources, including physiology, that neuroanatomy was the weakest section of the Anatomy Department, and that improvement in that area should be a primary objective. From the final list of candidates, Kenneth V. Anderson (BA, Carleton, 1960; MS, Brown, 1963; Ph.D., Brown, 1964) was chosen for the chairman's position (Fig. 16). Anderson was a Professor of Anatomy (Neuroscience) at Emory Univer-



Fig 15. — Carroll R. Ball, Ph.D. Photograph Circa 1995.



Fig 16. — Kenneth V. Anderson, Ph.D. Photograph Circa 1983.

sity. Both his MS and Ph.D. were in experimental psychology. At the time of his second interview Anderson had declared the Anatomy Department," Neanderthal", and despite the fact that Williams still had several months remaining on his contract, he requested immediate "takeover", foregoing the traditional phase-in time. Vice Chancellor Nelson was so impressed by this hyperactive, neuroscience person with the avowed goal of radically changing the department into a "state of the art", research-funded factory that he enthusiastically granted the request. There was such a truly remarkable CV, too, which included items ranging from impressive research funding to membership in a UFO sighting club. Williams was unceremoniously told to remove himself from the premises, and summarily accused in a memorandum to the Vice Chancellor, of misuse of department funds. Although the accusations were immediately disproved, no apology was ever forthcoming, from any source.

And so the revolution began. Walls and partitions came down to increase space for research; most support areas, including bathrooms, were threatened with conversion into "new" office/lab space. Offices, labs, and even student lockers were cleaned up and repainted in bright "stimulating" colors, although black ceilings, presumably to enhance concentration, were required in all areas. The departmental office and the chairman's private office were gutted and lavishly redecorated in a manner that would have done credit to a junk bond brokerage firm. To emphasize the new neuroscience thrust of the department, a grand neuro-cored consortium with Neurology, Neurosurgery, Physiology and Pharmacology was proposed. A request to change the name of the Department from anatomy to neuroscience was submitted to the Vice Chancellor; it, however, failed to gain approval in the executive faculty, reportedly due to the objections of Dr. Guyton of Physiology. A flurry of faculty meetings were called to discuss the critical issue of a departmental logos. A special committee, headed by Dr. William D. Davenport, was charged with gathering data from heraldic sources in order to provide an appropriate emblematic design. Alas, the administration found the potential cost prohibitive, and turned down this request, also.

All junior, nontenured faculty were either fired outright or served notice that they would be. Tenured, senior staff members were stripped of their course directorships, all medical center committee assignments, and for the most part, relegated to laboratory corners or storerooms for office space. An example of the deliberate effort to denigrate the tenured faculty was that the senior

member of the department, Dr. Ball, was ordered to vacate, within twenty-four hours, the office which he had occupied for some twenty years. A choice of three storage areas was offered to Dr. Ball in compensation; one was accessible only through the histology lab, another was a hall closet, and still another was in the basement across from the cadaver storage unit. Dr. Ashburn was impressed into a role of involuntary servitude as a technician for Anderson's vicarious "research" projects. The every move of the senior faculty was carefully monitored, documented and duly noted in personnel files.

The proclaimed strategy for achieving the ultimate "state of the art" level in the "formal courses" was "to produce adventures in learning that are more contemporary and have greater depth than has been the case in the past"; resulting in courses that are "exciting and palatable" to the students.[13] In actuality, departmental courses were de-emphasized, reduced in hours and in the case of the embryology course, completely done away with. The independent concept of development, it was said, lacked merit, and such little as was "needed" could easily be absorbed by other courses. Also, "students seemed to have too many scheduled contact hours and could better utilize more free time". Ironically, the scheduled embryology time was immediately taken up by the course in biochemistry.

New faculty, all with research interests in neuroscience, and frequently with little or no training in basic anatomy, were brought in, doubling the original staff size. Such newly arrived persons were placed in charge of the reorganized, newly redirected departmental courses. Dr. Clower was placed in charge of the body donor program in order to give the department complete control of supply and demand.

Research, research grant proposals, and research grant funding, all were battle cries of this heady, "cutting edge" Department. The submission of a grant proposal was declared just cause for celebration, and was fittingly toasted with a "bit of brandy" in the executive office.

Almost five years, to the day, this hydrogen sulfide filled balloon burst. A terse memo on a Monday morning in October informed the faculty that Dr. Anderson had "resigned". It seems that the attention of the personnel office had been directed to certain "inaccuracies" contained in Anderson's current Annual Report, namely that his personal publication listings were impossible to verify, and that practically 100% of the chairman's listed grant funding was nonexistent.[13]

Anderson was never seen again in the Department. All of which gave a new, possibly unique meaning to the Old Testament expression, that "he who lives by the sword may well die on the cutting edge"!

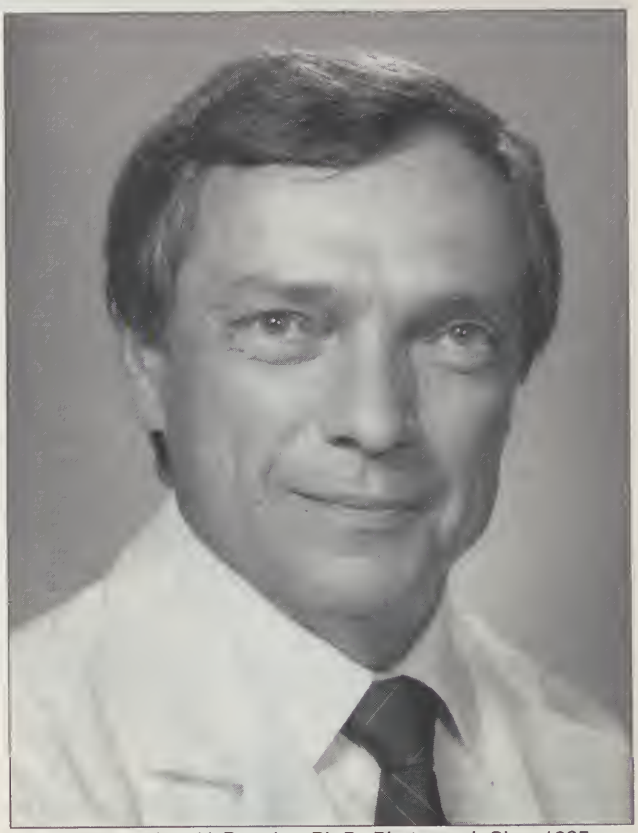


Fig 17. — Ben H. Douglas, Ph.D. Photograph Circa 1995.

The following excerpt from a letter dated September 13, 1984, from Dr. Charles W. Hooker, former Chairman of Anatomy at the University of North Carolina, to Dr. Lane Williams, former Chairman of Anatomy at the University of Mississippi Medical Center, is a poignant commentary on what was happening in anatomy departments everywhere, and coincidently at Jackson, Mississippi.

"Who or what is responsible for the subversion of anatomy in this country? Why are so many departments now chaired by psychologists, pseudo-biochemists, people who call themselves neurobiologists, but are in reality little more than braggarts, etc.? Are there no good anatomists, or is the situation akin to the railroads' extermination of the passenger trains? The teaching of anatomy is on the way to becoming so poor that the reason for having departments of anatomy is being lost. Is our generation responsible?"

Dr. Ben H. Douglas (BS, Miss. College, 1956; Ph.D., UMC, 1964), on a moments notice was designated to serve as acting chairman while a search committee sought a replacement for Anderson (Fig. 17). In addition to his position as Professor of Anatomy, Douglas was also Assistant Vice Chancellor for Graduate Studies. He had

replaced Dr. Williams who had occupied that position prior to his retirement. As acting chairman, Douglas attempted to restore some degree of integrity to the courses offered by the department. His basic strategy was to place all gross courses, whether medical or dental or nursing, under the direction of Dr. Ashburn. Ashburn would also be in charge of the body donor program. Dr. Ball would have an equivalent position with regard to all microscopic anatomy courses. Probably the most significant contribution that Douglas made was to revoke the termination notices of Dr. Norman A. Moore and Dr. Lloyd B. Gallimore. Loss of these two individuals would have been disastrous for the department's teaching program.

Dr. William L. Clem, Chairman of Microbiology, chaired the search committee. Among the final five candidates considered was a Dr. Jacobson from Utah, who in a meeting with the anatomy faculty, stated that his philosophy of departmental administration could be summed up with, "if you don't show up on Sunday, don't bother to show up Monday". During the same visit he presumably told Vice Chancellor Nelson that his ambition was to take over Nelson's job as well. For some reason or another, he was not selected. Dr. Douglas, himself a strong contender was a victim of a concerted and energetic lobbying effort by the neuroscience contingent of the Department, some of whom devoted considerable effort to influence the selection committee, or any one else that would lend their attention. The ploy was that the department now had so much invested in a neuroscience centered operation that to redirect the Department would not be responsible. The only neuroscience individual to make the final cut was Dr. Duane E. Haines, and he was the one selected to be the next chairman. He officially assumed the chairmanship on October 1, 1985.

Dr. Haines (BA, Greenville College, 1965; MS, Mich. State, 1967; Ph.D., Mich., 1969) is a native of Springfield, Ohio. His Ph.D. reflects both anatomy and physical anthropology (Fig. 18). Prior to coming to Mississippi he had appointments in the anatomy departments of the Medical college of Virginia (4 years), and West Virginia University (12 years). As Chairman of Anatomy at UMC he has vigorously continued the emphasis on the neurosciences and, in addition has promoted research in cell biology. Research interests of newly hired faculty reflected each of the areas. Opening of the Guyton laboratory research building in 1993 significantly increased available work space for the Department. Haines, a would-be workaholic himself, has strongly encouraged grant-funded research and/or other scholarly pursuits. Faculty who either did not have

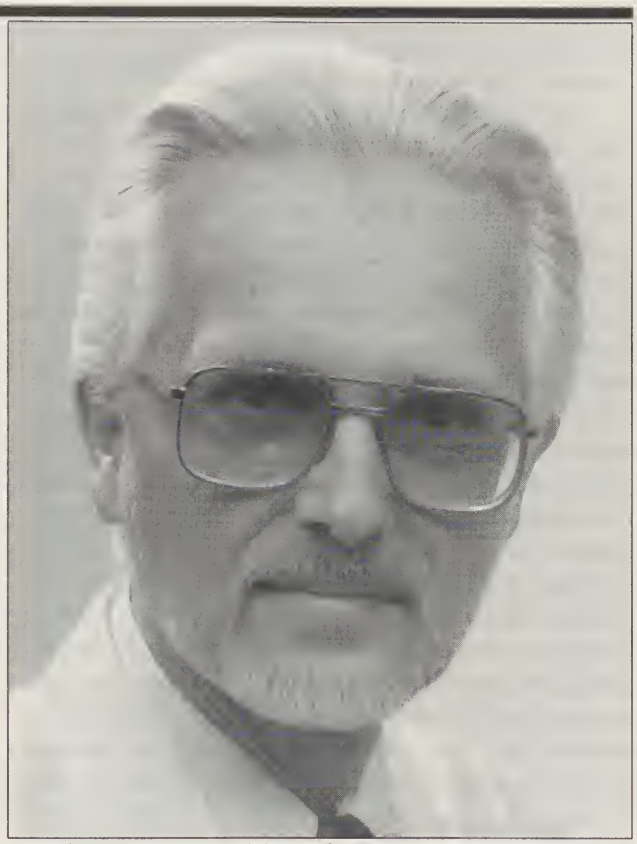


Fig 18. — Duane F. Haines, Ph.D. Photograph Circa 1995.

research funding or who did not choose an active research program have been assigned the bulk of the teaching load. Considerable effort has been made to establish a graduate program with individuals, mostly from the Orient, working on neuroscience related programs. The faculty now numbering some eighteen individuals is the largest in the department's history.

Dr. Ashburn's problems with alcohol which had intensified during the Anderson era became further exacerbated, and with increasing frequency he was unable to perform his duties as director of gross anatomy. Although fellow faculty members attempted to cover for him when ever possible, eventually the erratic behavior became too obvious to conceal. Dr. Haines attempted to deal with the matter with consideration and restraint, but the situation took on a more serious turn when Ashburn made death threats on Haines' life. The threats were so intimidating that the administration wisely provided campus security to escort him to and from the building and to stand guard at his office door. Shortly thereafter, the administration was made aware of Ashburn's inability to carry out his assigned duties, and in June of 1988, his resignation was requested. He returned to his east Tennessee origins, and within five years died a tragic death. Dr. Gallimore was given responsibilty for the body donor program. Under

his direction an adequate record keeping system was instituted for the first time in the department's history.

In 1990 a refrigeration storage facility replaced the long outmoded, Gothic vats which had been used for cadaver storage since the school opened in Jackson in 1955. The facility had a tiered storage capacity of 88 bodies with a separate freezer unit for two bodies. About the same time the body donor program began to be more acceptable to the public. Several factors seemed to be operative. Traditional funeral and burial costs were increasingly expensive, and the idea of making a significant contribution to medical education was better understood and appreciated. In 1993, Dr. Moore was appointed director of the body donation program; through his computerized efficiency in record keeping, and compassion for potential donors and/or their families the program now provides adequate study material for the entire medical center. Dr. Moore, as course coordinator of medical gross anatomy has gone to considerable lengths during the course orientation to imprint upon the freshmen the need for proper respect and appreciation for this ultimate gift. Yet another reinforcement for the body donation program came in 1996 when Vice Chancellor Connerly designated a plot on the campus for the burial of remains; the area is replete with a large granite monument. He also instituted an annual memorial service at the burial site by way of recognition of those who had contributed and whose remains are buried there.

During the 1980's the typical medical student's image took a more conservative bent. Whether this was a reflection of the seemingly relentless shift toward various forms of socialized medicine, the national pronouncement that too many doctors were being trained (particularly in the specialities) by too many medical schools, the changing economic/social climate, or a combination of all of these was not clear. Certainly the motivation seemed to shift from professional dedication to economic drive. Classes organized elaborate note taking systems; upper classmen peddled "old notes and tests" at a considerable profit. There were demands, sometimes subtle, sometimes not so subtle, for "no frills" lectures. Detailed lecture notes from the faculty or handouts to be made available prior to the lectures, were requested along with assurances that test questions would be derived only from such sources. The consensus and individual grievances were made known though student evaluations and critiques of both courses and faculty. Diehards like Dr. Ball tried furtively to preserve the formal lecture formate. His attempts to maintain class alertness with the use of interspersed slides of the fine arts (such as works by Renior) were met with complaints of sexual harassment. Even slides of congenital abnormalities of the external genitalia were said to be "offensive and inappropriate". Now comes "computer assisted instruction" introduced in 1997, either impersonally "canned", or operated from a possibly distant keyboard. The image of the lovable, supportive old professor fades into obsolescence.

Just as the electron microscope dramatically expanded the horizons of microscopic anatomy in the 1950's, so has rapidly evolving molecular biology greatly expanded the limits in the 1990's. When you combine the molecular concept with projected physiological function, the term "microscopic anatomy" becomes so archaic as to be of little or no value. The days of the light microscope in a laboratory setting are numbered, the concept replaced by a microchip. Neurosciences will most probably follow in this wake. Adapting the computerized "virtual reality" of gross anatomy to the various imaging techniques now available can demonstrate in great detail and accuracy both normality and pathology. Invasive procedures with lasers manipulated by robotics bring clinical correlation to new thresholds.

The currently accepted learning process for students now seems to be to store as much information in the personal memory bank as possible for retrieval during examinations. The now required National Board Subject Exams represent an initial hurdle for freshman and the USMLE for sophomores and seniors, the ultimate goal. The whole to be accomplished in the least possible, most efficient time with the thought process suppressed whenever possible.

Is this approach effective? Is this a mission accomplished? Judging by the students performance on the subject board exams, apparently it is. Scores on the board exams for microscopic anatomy and neurobiology are at, or slightly above the national average, while the gross exam scores are significantly above the national average. In retrospect, the hundreds of practitioners of medicine, dentistry and nursing over the state and elsewhere, attest that the mission of the Anatomy Department has been accomplished.

With the human body converted to computerized "virtual reality" what is the need for actual hands-on dissection?[24] A slight pressure on the ODOR key will activate an atomizer which will release a simulation of the "once experienced, never forgotten" odor of the gross lab. Will the gross lab disappear, also? I think not. Not if you keep in mind what the term "anatomy" means—that it is to dissect or cut!! To paraphrase William Faulkner, "it will endure".

	A	B	C	D	E	F
1	NAME	YEARS	DEGREE	COURSE TAUGHT	TITLE	
2	James B. Bullitt	1903-1913	M.D. Univ. of Virginia	Gross	Professor	
3	Waller S. Leathers	1903-1924	M.D. Univ. of Virginia	Physiology & Histology	Professor, Dean	
4	Hugh N. Page	1908-1910	M.D.		Instructor	
5	John C. Herrington	1908-1909	B.Ph.		Assistant	
6	R.C. Rhodes	1910-1911	M.A. Vanderbilt	Gross	Assistant Professor	
7	Rockwell E. Smith	1911-1913	M.D.	Gross	Assistant Professor	
8	Orren W. Hyman	1912-1913	M.S. Univ. of North Carolina	Embryology	Assistant Professor	
9	J. Wm. Buchanan	1913-1915	B.S. Ohio	Embryology	Ass. & Assoc. Professor	
10	C.L. Andrews	1913-1914	M.D. John Hopkins	Gross, Topographical	Acting Professor	
11	J.O. Crider	1913-1930	M.D. VA	Histology	Professor, Dean	
12	R.M. Strong	1914-1916	Ph.D Harvard	Gross, Topographical	Professor	
13	Fred A Griffith	1915-1916	M.A.	Embryology	Associate Professor	
14	Frederick Lee Highsaw	1916-1918	A.B., M.A.	Embryology	Associate Professor	
15	Chas. F. Degaris	1917-1924	M.D. Wash. (St. Louis)	Gross, Topographical	Professor	
16	Howard A. Dennee	1918-1919	B.A. Univ. of Buffalo	Embryology	Act. Assoc. Professor	
17	Harrison R. Hunt	1919-1924	Ph.D Harvard	Embryology	Professor, Chairman (Bio)	
18	Francis A. Threlkeld	1922-1924	A.B., M.A.	Gross	Instructor	
19	B.L. Robinson	1916-1923	B.A., M.A., Wis.	Gross	Act. Prof.	
20	George Erwin Johnson	1923-1924	M.S., Ph.D Chicago	Embryology & Biology	Professor	
21	T.E. Wilson	1924-1926		Histology	Acting Assistant Professor	
22	Philip Lee Mull	1924-1937	B.S.,M.D. University of Louisville	Gross, Topographical	Professor, Dean	
23	L.E. Thatcher	1924-1926	A.B.	Embryology & Biology	Professor	
24	J.B. Looper	1927-1945	Ph.D VA; M.D. Chicago	Embryology & Histology	Prof., Chairman, Dean	
25	Alonzo E. Hardison	1933-1934	B.S.	Gross, Hist., & Emb.	Instructor	
26	J.B. Taylor	1934-1935	A.B., M.S.	Gross, Hist., & Emb.	Instructor	
27	E.W. Green	1935-1936	M.D.		Research Associate	
28	John M. Weir	1935-1937	B.S.	Gross, Hist. & Emb.	Assistant Professor	
29	Laura D. Ladd	1936-1942	B.A.	Gross, Hist. & Emb		
30	John James Fahey	1936-1937	M.D. Ohio State	Gross, Topographical	Acting Professor	
31	A.R. Buchanan	1937-1939	M.D. Iowa	Gross, Topographical	Professor	
32	D.S. Pankratz	1939-1961	Ph.D KA; M.D. Chicago	Gross, Topographical	Professor, Chairman, Acting Dean, Dean	
33	Margaret Long	1942-1944	B.S., M.S., Ph.D.	Gross, Hist., & Emb.	Instructor	
34	J.M. Hill	1945-1955	M.S.	Gross	Instructor, Assistant Professor	
35	Ira D. Hogg	1946-1958	A.B., M.A., Ph.D. Univ. of Kansas	Gross, Embro, Neuro	Professor, Chairman	
36	R.J. Nichols	1946-1954	Ph.D Illinois	Histology	Assoc. Professor, Professor	
37	J.W. Ward	1946-1970	B.A., Ph.D. Univ. of MS	Gross, Embro, Neuro	Assoc. Professor, Emeritus	
38	C.M. Murry	1948-1949	M.D.	Gross	Instructor	
39	J.B. Rogers	1948-1949	M.D.	Gross	Instructor	
40	H. Jack Burnham	1949-1951	D.D.S	Gross	Instructor	
41	Lee Rogers	1949-1951	M.D.	Applied Anat.	Assistant Professor	
42	F.H. Poteete	1950	M.D.	Gross	Instructor	
43	Hugh Semmes Rayner	1950	M.D.	Gross	Instructor	
44	Henry C. Tracy	1951-1958	Ph.D. Brown	Neuroanatomy	Associate	
45	James Hill	1951	M.D.		Assistant Professor	
46	Warren W. Johnson	1951-1952	M.S., M.D. Univ. of MS		Instructor	
47	Willard H. Parsons	1952	M.D.	Surgical Anatomy	Assoc. Professor	
48	Malcolm A. Franklin	1946-1956	B.A. Univ. of MS		Instructor	
49	Maria Ryzen	1954-1955	Ph.D.	Hist. & Emb.	Assistant Professor	
50	William L. Read	1954	M.D.		Instructor	
51	Martin Ajemian	1955-1974	B.S., Ph.D. Georgetown Univ.	Gross	Assoc. Professor	
52	Russell E. Morris, Jr.	1955-1957	M.S., Ph.D. Emory University	Neuroanatomy	Instructor	
53	Robert Caldwell	1955-1956	M.D.	Surgical Anatomy	Assistant Professor	
54	James C. Griffen	1956	M.D.	Surgical Anatomy	Assistant Professor	
55	Jorg A. Rodriguez	1957	M.D.	Surgical Anatomy	Assistant Professor	
56	W. Lane Williams	1958-1979	Ph.D. Yale	Histology	Professor, Chairman	
57	Ervin W. Powell	1960-1966	Ph.D. Western Reserve	Neuroanatomy	Asst. Prof., Assoc. Prof.	
58	Carroll R. Ball	1961	Ph.D. Univ. of MS	Histo, Embro, Neuro	Professor, Acting Chairman	
59	Allen Ashburn	1962-1988	Ph.D Univ. of MS	Gross	Professor	
60	Duane K. Rorie	1964-1966	Ph.D. Univ. of MS	Gross	Instructor	
61	Bennie R. Clower	1966-	Ph.D. Univ. of MS	Neuroanatomy, Histo.	Professor	
62	Bobby C. Spell	1967	M.D.	Orthopedic Surgery	Clinical Instructor	
63	Reginald K. Boler	1968-1970	Ph.D. Univ. of MS	Neuro, Histo, Gross	Asst. Prof.	
64	Charles E. White	1969	Ph.D. Univ. of MS	Gross	Part time Instructor	
65	Edward R. Wilson, Jr.	1969	Ph.D. Univ. of MS	Gross	Part time Instructor	
66	Hayes Williams	1970-1972	Ph.D. Univ. of AL at Birm.	Gross	Instr., Asst. Prof.	
67	John L. McNair	1971-1974	Ph.D. Univ. of MS	Neuro	Instructor, Assistant Professor	
68	Wilton L. Marsalis	1972-1976	Ph.D. Univ of MS	Histology	Instr., Assistant Professor	
69	Michael Kendall	1972-1974	Ph.D. Univ. of Louisville Med. Center	Gross	Assistant Professor	

	A	B	C	D	E	F
70	Frank C. Salter	1972-1976	Ph.D. Univ. of AL at Birm.	Neuroanatomy, gross	Instr., Assistant Professor	
71	Roland T. Abangan	1973-1974	M.D.	Neuroanatomy	Clinical Asst. Prof.	
72	Arther D. Collins	1973-1974	Ph.D. Univ. of MS	Gross	Asst. Professor	
73	Donald W. Fisher	1973-1974	Ph.D. Univ. of MS	Gross	Instructor	
74	William D. Blome	1974-1975	Ph.D. Univ. of MS	Neuroanatomy	Instructor	
75	Mark Edward Clasen	1974-1975	Ph.D. Univ. of MS	Gross	Instructor	
76	Macon M. Weaver	1974-1981	Ph.D. Univ. of MS	Gross	Asst. Professor	
77	Tuan Tran	1974-1974	Ph.D. Univ. of Louisville	Gross	Research Associate	
78	William D. Davenport	1975-1983	Ph.D. Med. College of Georgia	Embryo, histology	Assistant Professor	
79	Lloyd B. Gallimore	1975-1998	Ph.D. Bowman Gray Med. School	Gross, Histo	Associate Professor	
80	John H. Romfh	1975-1982	Ph.D. Univ. of Alabama-Birmingham	Gross, Neuro	Associate Professor	
81	Norman F. Capra	1976-1990	Ph.D. Univ. of Ala. at Bir.	Neuro, Histo	Associate Professor	
82	Norman A. Moore	1976-	Ph.D. Univ. of TX Medical Branch	Gross, Histo, Embryo	Associate Professor	
83	Ben H. Douglas	1977-1997	Ph.D. Univ. of MS	Histology	Prof., Acting Chairman	
84	Larry J. Tillman	1977-1985	Ph.D. Univ. of MS	Histology	Assistant Professor	
85	John Phillip Naftel	1978-	Ph.D. Univ. of Ala.-Birmingham	Histology, Neuro, Gross	Associate Professor	
86	Kenneth V. Anderson	1979-1984	Ph.D Brown	Neuro	Professor, Chairman	
87	Nancy Hayes	1980-	Ph.D Chapel Hill	Neuro	Assistant Professor	
88	John Addis	1981-1985	Ph.D. Univ. of Michigan	Histology	Assistant Professor	
89	James Lynch	1981-	Ph.D. Stanford Univ.	Neuro	Professor	
90	Richard Nowakowski	1981-1985	Ph.D Harvard Univ.	Histology	Assistant Professor	
91	Robert P. Yezierski	1981-1987	Ph.D. W. Virginia Univ.	Neuro	Assistant Professor	
92	Pat Hardy	1983-	Ph.D. Medical College of Virginia	Gross, Neuro	Associate Professor	
93	John Daniel Porter	1983-1989	Ph.D. Univ. of Vir. Med. Coll.	Gross	Assistant Professor	
94	Duane E. Haines	1985-	Ph.D. Michegan State Univ.	Neuroscience	Professor , Chairman	
95	David H. Bernanke	1986-	Ph.D. Univ. of South Carolina	Gross	Associate Professor	
96	Paul May	1986-	Ph.D. Duke	Histology	Associate Professor	
97	Susan Warren	1987-	Ph.D. Penn State	Gross	Associate Professor	
98	William Roy	1987-	Ph.D. Univ. of West Virginia	Gross, Neuro	Associate Professor	
99	March D. Ard	1988-	Ph.D Univ. of Conn.	Histology	Associate Professor	
100	James B. Hutchins	1989-	Ph.D Baylor College	Neuro	Associate Professor	
101	Terence Paul Ma	1990-	Ph.D. Wayne State Univ.	Gross	Associate Professor	
102	Gregory A. Mihailoff	1990-1997	Ph.D. Ohio State Univ.	Neuro	Professor	
103	Allen R. Sinning	1990-	Ph.D. Univ. North Dakota	Gross	Associate Professor	
104	Michael King	1993-	Ph.D. Univ. of Washington	Neuro	Professor	

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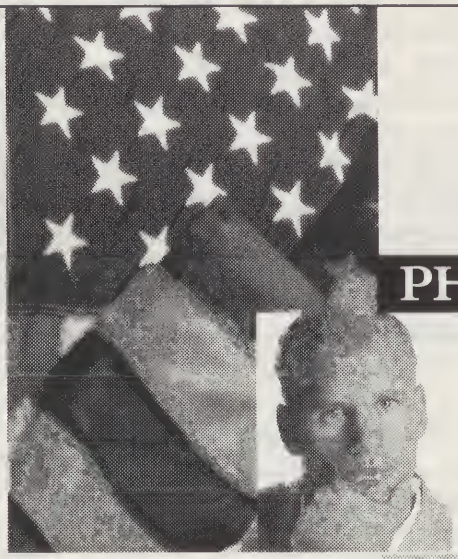
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CASE RECORDS OF THE DEPARTMENT OF MEDICINE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

CLINICOPATHOLOGIC CONFERENCE XX

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Radiological Findings: William T. Bottoms, M.D.
Pathological Findings: Karen T. Hughes, M.D.

CASE PRESENTATION

The patient is a 21 year old African American female who presented to her local physician in August of 1996 with complaints of nausea, a nonproductive cough, and fever for 5 days. She was also noted to have a left anterior cervical lymph node and was placed on Ampicillin for a probable upper respiratory infection. She subsequently developed vomiting, diarrhea, diffuse abdominal pain, and generalized edema. She saw a second physician who diagnosed her with a UTI and changed her to Norfloxacin. When her symptoms did not improve, she presented to the University Emergency Room. She was found to be in renal failure with a creatinine of 5.4 and was admitted to Nephrology. Workup and management during the initial hospital stay included a renal ultrasound, which showed large kidneys bilaterally. A 24 hour urine was done which showed 7.5 grams of protein. Her ANA was negative and her HIV was negative. She had a renal biopsy which showed glomerular disease with fusion of foot processes and acute tubular necrosis. She was started on Prednisone at 60mg/day and was diuresed with Furosemide. Her course over the next few months included multiple admissions for recurrent peripheral edema and various GI complaints. EGD showed a small gastric ulcer and duodenitis. A flex sig was normal. She had a repeat renal biopsy after four weeks of Prednisone that still showed ATN and minimal change disease. There was no clinical response after 12 weeks of Prednisone, so Imuran was added. She did have an admission for worsening edema, fever, and bilateral pulmonary infiltrates that responded to IV Bactrim and Erythromycin. During the hospital stay she also required hemodialysis temporarily. After 16 weeks of Prednisone and four weeks of Imuran, her proteinuria had actually increased while her creatinine was stable. The Imuran was discontinued and her Prednisone was tapered. In late December, she presented to the ER with abdominal pain, persistent diarrhea, and fever to 101. She had been seen one day prior to that in the ER and was placed on Cipro for pyuria. She was admitted to the Nephrology Service for further evaluation.

Past medical history was significant for two spontaneous abortions and gonorrhea. She had no past surgical history. Medications were Prednisone at 10mg/day, Lasix 80mg b.i.d., and Metolazone 10 mg b.i.d., as well as Calcium Carbonate and a multi-vitamin. She had no allergies. She had a 5 pack/year history of smoking, occasional alcohol, and no illicit drug use, but had multiple sexual partners in the past.

Family history was remarkable only for hypertension and type II diabetes, and review of systems was unremarkable.

The admission physical revealed a blood pressure of 113/78, pulse of 125, respiratory rate of 22, and a temperature of 100.1. Generally she was a well developed female, oriented times four. HEENT exam was normal. Neck was supple with no JVD, and no adenopathy was noted at that time. Chest and lung exams were normal. Back had no CVA tenderness. Abdomen was slightly tender diffusely with no rebound or guarding, no hepatosplenomegaly, and no ascites appreciated. She had only trace edema. On neurological exam her cranium nerves were intact with no focal deficits. Rectal exam revealed external hemorrhoids and brown stool that was occult blood positive.

Lab work revealed a white count of 13, a hematocrit of 41.2, a platelet count of 378, sodium of 139. Her potassium was low at 2.9, chloride was 116 with a bicarb of 15, and her BUN and creatinine were 27 and 2.8. Total protein was 4.4, with an albumin of 1.7, amylase of 31, and lipase of 30. Urinalysis showed > 300 mg/deciliter of protein, large blood, trace ketones, 500 mg of glucose, pH of 6.5, specific gravity of 1.026, and 17 white cells and 17 red cells. Chest x-ray and abdominal films were normal.

Upon admission she had blood cultures drawn and her Cipro was continued. Stool was culture negative and negative for C-difficile. Blood cultures also returned negative. Her abdominal pain was assessed with an upper GI with small bowel follow-through which was normal. Because of persistent daily fevers, a CT of the head was done which showed maxillary sinusitis and possible mastoiditis. She was treated with Ceftriaxone per the recommendations of the ENT Service and became transiently

afebrile. However, she remained in the hospital as she continued to have fever occasionally and her abdominal pain, nausea, and diarrhea persisted. About three weeks after admission, she was noted to have significant left arm edema and complained of left shoulder pain. A duplex Doppler was done to rule out axillary vein thrombosis. No thrombosis was visualized, but there was a mass in the area of the left subclavian vein that was compressing the vein. An ultrasound showed a 4 cm lobulated mass that was lateral to the thyroid and a diagnostic procedure was done.

The primary questions for the discussant are: 1) discuss the differential diagnosis and how to approach this patient, 2) what is the most likely diagnosis, and 3) in what clinical situations is one prompted to aggressively pursue the etiology of an enlarged lymph node? Radiology will demonstrate and discuss the radiographic findings.

DR. BOTTOMS: A film from admission in August reveals some bi-basilar hyporaeration changes and a small left pleural effusion. One of the earlier ultrasounds show the right kidney to be right around 13.2 cm, and generally 9 - 13 cm is about the size for women, so it is a little enlarged and there is a question of some very small amount of perinephric fluid around it. The left kidney is also somewhat enlarged at 13.24 cm, and the corticomedullary junction was not quite as distinct as usually seen and inflammation could not be excluded. In August, she also had a CT of the abdomen without any contrast. This also demonstrated bilaterally prominent kidney size. Chest CT in November of 1996 shows that there is now a right pleural effusion, maybe a very small left effusion still remaining. There were some very fine perihilar infiltrates which were suspicious for pulmonary edema that subsequently resolved. CT of the head in January of this year showed that there was some opacification in the mastoid air cells, suspicious for mastoiditis. A sinus series done at that time showed some fluid levels in the maxillary sinuses, as well. An ultrasound done for left arm swelling revealed a large, lobulated, hypoechoic mass lateral to the great vessels and thyroid which correlates nicely with what we saw in her soft tissue neck scan done shortly thereafter. This was without contrast due to her renal condition, but a large soft tissue mass was revealed that correlates well with the ultrasound findings obviously suggestive of a matted area of adenopathy. Also on her chest scan done at the same time she had, again, some bilateral pleural effusions and some bilateral axillary adenopathy.

DR. HICKS: The salient features of the case as I saw them were as follows: We start off with a relatively young woman who was presumably previously healthy with no known systemic diseases, was not chronically ill, and on no medications. She had had two spontaneous abortions which brings up the possibility of lupus, an anticardiolipin antibody, or something else to cause spontaneous abortion. I would like to know if she had any living children. She was a relatively heavy smoker, but of only short duration. She did have multiple sexual partners and, of course, that is an important part of the history. It brings up the possibility of sexually transmitted diseases, particularly HIV infection.

Her physical exam was important for what was not there, as opposed to what was there. She was slightly febrile, tachycardiac, mildly tachypneic, and presumably not jaundiced. At the time of this physical exam there was no palpable adenopathy, although there apparently had been on her initial presentation to her local doctor. She had no organomegaly and she was fecal occult blood positive. Laboratory also is not very helpful. She had a moderate monocytosis which is very nonspecific and can be seen in a number of malignant, inflammatory, and infectious processes. She was hypokalemic, which I attributed to her diuretic therapy, although she could have had renal tubular problems. She was hyperchloremic and had a bicarbonate of 15 with an anion gap of 8. I attribute that narrow anion gap to the fact that her albumin was at least 2.5 grams below normal. That would account for most of that, as albumin acts as an unmeasured anion. She was fairly azotemic, although not as azotemic as she had been on her initial presentation. Urinalysis revealed a lot of protein and a few red cells and a few white cells. There was no mention of a urine sediment.

When she initially presented, and then later on in the course, she did have lymphadenopathy. Initially, the only thing that we were told was the location. It was an anterior cervical node. We were not told anything about the size: was it pea-sized or the size of an egg, or somewhere in between. We were not told of the consistency. Was it rubbery as one might see with a lymphoma, hard and fixed like you might see with a solid tumor, or fluxuant, which would suggest infection? Was it movable or fixed? Was it tender or warm? Did it change in size that she or any of her other doctors were aware of? Did it resolve spontaneously? Presumably it did resolve, because it is not mentioned again until weeks or months later. When one mentions lymph nodes in one's physical exam, one needs to include all of the above characteristics because they are important.

The most difficult part of the case for me to try to make sense of is this chronic, seemingly waxing and

waning variety of gastrointestinal symptoms which at one time or another included nausea, vomiting, diarrhea, and generalized abdominal pain which apparently was fairly severe. She had a lot of diagnostic studies done to come up with the etiology for this. She had an EGD which showed duodenitis and gastric ulcer. This brings up the question of NSAID ingestion. We don't know that, but she may have been self medicating. She had a flexible sigmoidoscopy which was negative, upper GI, and small bowel follow-through were normal. Stool for C. difficile was negative, making pseudomembranous colitis or antibiotic-related diarrhea less likely. Stool culture was negative. I didn't see fecal leukocytes reported. I don't know if that was done or not, but that is a good test to do to screen people for either acute bacterial diarrhea or inflammatory bowel disease. If they don't have fecal leukocytes, they probably don't have either of those. It did seem to me in reading through the protocol that she seemed to have flares of GI symptoms every time she took a course of oral antibiotics, so my best guess is that her GI symptoms were not related to the primary disease process but more a manifestation of probable antibiotic-associated diarrhea.

Fever seemed to be a major part of her clinical course. She was febrile on more that one occasion during this course. I would like to know if she had true shaking chills or rigors which one would associate more with a bacterial infection. Did she have night sweats? If we were worried about a systemic infection or a cancer or lymphoma, we would want to know if she had night sweats. What was the pattern of the fever? Was it constant, every day, or did it come in episodes of being febrile and then periods of being afebrile? We don't know that. Did she lose weight during this time? It is probably difficult to tell what happened to her ideal body weight since she had a lot of apparent edema from being hypoproteinemic. I imagine it would be difficult to figure out what her ideal body weight was and track it throughout the course of this illness with her being on and off various doses of diuretics and Prednisone.

When she presented, she was fairly severely azotemic and had large kidneys. I tried to find my differential diagnosis of large kidneys which I have written down somewhere, but I never could find it. Things that come to my mind are amyloidosis, infiltrative diseases like myeloma, diabetes, polycystic disease, etc. The fact that they were not small suggests that all of this was a fairly acute process regardless of the etiology. She had nephrotic range proteinuria. We don't know what her urine sediment looked like, but presumably it was fairly benign. The biopsy is going to be helpful in trying to narrow down the differential diagnosis. She had minimal change disease and acute tubular necrosis. She was ANA negative. That makes it very unlikely that she had lupus. She was HIV negative, making HIV nephropathy unlikely. Her failure to respond to steroids, even though she had been on them for 2 or 3 months, is important. Most adults with minimal change disease that is not due to anything else will respond favorably if treatment is continued for 2 - 3 months. Her proteinuria never did improve. Her azotemia improved, probably because whatever caused her ATN, which may have been volume depletion or drugs, got better. I don't think her glomerulopathy ever improved, as evidenced by the fact that she continued to have massive proteinuria.

The main pathologic change found in minimal change disease is fusion of foot processes. The reason that it is called minimal change disease is apparently in the days before electron microscopy, one could not see anything wrong with these glomeruli with regular light microscopy. Only with the advent of the electron microscope could one tell what the underlying pathology was. For some reason, something insults those foot processes: They either lose their anionic charge or the pore size changes and they leak protein into the urinary space, then out into the urine and develop proteinuria to varying degrees. There are all sorts of disease processes that are associated with minimal change disease.

The incidence of minimal change disease actually goes down with age and the incidence of membranous glomerular nephropathy goes up. The incidence of amyloidosis goes up with age as does diabetes.

The patient had bibasilar pulmonary infiltrates at least once. They were presumed to be infectious and responded to Erythromycin, suggesting that she had a community-acquired pneumonia. Bactrim was empirically used in case she might have an opportunistic pathogen like Pneumocystis. The fact that her pulmonary infiltrates resolved on antibiotics makes me think that it probably was infectious. Other possibilities include 1) drug induced, although Imuran is not one of the major drugs that causes pulmonary toxicity, it is possible; 2 lymphangitis spread of carcinoma; or 3) lymphoma.

The sinusitis and mastoiditis symptoms, of which she never complained, were probably discovered because a search was being made for the cause of her continued febrile illness. A CT was done and this seemingly unexpected finding appeared. I don't think it is really related to the case, although I did include one thing in my differential diagnosis which could be related to this.

Some of the more common examples of glomerular disease due to secondary causes can be divided into three large categories: 1) Infections - HIV, Hepatitis B or C,

syphilis, malaria, bacterial endocarditis, schistosomiasis, shunt nephritis; 2) Drugs - nonsteroidals, gold, Penicillamine, heroin; and 3) Neoplastic diseases - myeloma and other plasma cell dyscrasias, carcinomas (especially lung, breast, and ovary) and Hodgkin's and non-Hodgkin's lymphoma. Not all of these have been associated with minimal change disease. HIV nephropathy is usually focal sclerosis, although there are some cases of minimal change disease with HIV. The same goes for syphilis, which is usually membranous but can be minimal change. Endocarditis would not be likely in this lady because she did not have a heart murmur. She had a very prolonged course and repeatedly negative blood cultures. Carcinomas are most often associated with membranous nephropathy. Therefore, membranous nephropathy is most frequently seen in older people. Less common carcinomas can be associated with minimal change disease.

My differential diagnosis includes the following: 1) HIV - In a young woman with multiple sexual partners, adenopathy, and proteinuria, one can't ignore HIV-related illnesses. I am not going to put that at the top of the list mainly because the glomerular pathology not focal sclerosis, but minimal change disease. 2) Sarcoidosis - It is very prevalent in this area, especially in the African-American population, and can mimic many other diseases. It can certainly cause adenopathy and renal disease, although it usually doesn't cause nephrotic syndrome. More often it causes a granulomatous interstitial nephritis. 3) Medullary carcinoma of the thyroid. This is probably a zebra, but it is possible in a patient with a neck mass who has various GI complaints. Medullary carcinoma of the thyroid can occasionally be associated with a carcinoid-like syndrome which could have accounted for her GI symptoms and can be associated with amyloidosis, which could have caused her proteinuria. 4) Plasma cell dyscrasias - There is not much evidence for that. She does not have any cytopenias. She has no bone disease. She doesn't have anything in her renal biopsy that looks like a plasma cell problem, and she is a bit young to have that. 5) Solid tumors - In an older person the would probably be higher up in the differential. She had no evidence of having either a GI, lung, or breast malignancy. 6) Wegener's granulomatosis - I included this only because she had coexisting sinusitis and renal disease. The biopsy is certainly not typical for Wegener's. There are no crescents, there is no proliferation, and I don't believe that Wegener's has ever been associated with minimal change disease. 7) non-Hodgkin's lymphoma or Hodgkin's disease - I favor a diagnosis of Hodgkin's disease and it is my number one in the differential. If one looks at all of the diseases that cause secondary minimal change disease, Hodgkin's disease is right at the top, far ahead of non-Hodgkin's lymphoma or any of these other diseases I have mentioned. The first cases of coexisting nephrotic syndrome and Hodgkin's disease that I could find were five cases reported between 1939 and 1957. None of them had renal biopsies done so we don't know what the actual renal lesion was. Since then, the association of Hodgkin's disease and minimal change disease has been well documented in numerous cases with renal biopsies.

I was also asked to comment on the indications for lymph node biopsy. There are few hard and fast rules about that. I think there are some patients that everybody in this room would probably biopsy and there are some patients that no one in this room would biopsy. There are going to be a lot of patients in the gray area where you need more information or maybe observation for a period of time. I am sure that everybody in this room has had an enlarged lymph node at some time in their life and probably very few of us have had lymph node biopsies. One thing to consider is the age of the patient. If there was a young patient with acute pharyngitis and generalized cervical adenopathy, one would not biopsy that patient. They almost certainly have an acute viral or bacterial pharyngitis. Location may be important. Supraclavicular nodes usually need some sort of investigation because they are most often associated with either a lymphoma or solid tumor from the GI tract or chest. Unilateral cervical adenopathy also needs to be investigated particularly in patients without obvious evidence of a localized infection or in the older group who have risk factors like tobacco and alcohol use for ENT cancers. New onset of axillary or inguinal adenopathy in the absence of constitutional symptoms or signs of local infection probably ought to be evaluated with biopsy. Rapid change in size or consistency would be an indication for biopsy. If a biopsy suggests atypical hyperplasia, one should continue to follow that patient closely, look for more nodes, and watch the area that was biopsied because there is still indication for lymphoma.

DR. HUGHES: Two silver-stained preparations from this patient's kidney biopsy were received on August 9 and September 17, showed the same finding. There were a few tubules that show some mild changes of acute tubular necrosis. There was some loss of the epithelial cells and some reactivity to a few of the epithelial cells. There was some granular debris in a few of the lumens. The acute tubular necrosis changes were mild. Several of this patient's glomeruli did have a little mild hypercellularity, nonspecific; but otherwise all of her glomeruli were normal. There was no increased fibrosis

in the interstitium. The proximal and distal tubules looked red, but she would have increased fibrosis in the interstitium or tubular atrophy if it were a chronic disease. On this patient's renal biopsy, there were red blood cells that were in the capillary spaces. Some of the mesangial cells showed fusion and were essentially flat against the basement membrane. There were no changes in the basement membranes: no thickening, no thinning, and no evidence of immune complex deposition. The mesangial areas were essentially normal by electron microscopy and showed no evidence of deposition of dense deposits. This was minimal change disease. By immunofluorescence, there was some non-specific focal staining with the IgM in C3 which brings up the possibility of early focal segmental glomerulosclerosis, but there were good samples of the glomeruli. Pathology had 25-29 glomeruli per biopsy received, which was quite a few glomeruli and there were no segmental lesions. Without any kind of lesions like that by histologic examination, you can't really make a diagnosis.

The lymph node showed some fibrotic bands that were separating the nodal architecture out into nodules. There was an essential effacement of the lymph node architecture and there were areas of focal necrosis, as well. The effacement contained several lymphocytes and there were areas that had plasma cells, large pleomorphic cells, and a few typical Reed-Sternberg cells. There was an area of sclerosis that was present within the lymph node. **The diagnosis was Hodgkin's, medullar sclerosis type. There was no involvement of the bone marrow biopsy of the Hodgkin's disease and there were no granulomata.**

Dr. Files *is Professor of Medicine and Associate Chairman, Department of Medicine.*

Dr. Hicks *is Associate Professor of Medicine.*

Dr. Bottoms *is a Resident in the Department of Radiology.*

Dr. Hughes *was a Resident in the Department of Pathology.*

Drs. Robbins, Stewart, and Wofford *were Chief Medicine Residents in the Department of Medicine at the University Medical Center in 1996-1997.*

Mississippi Methodist Rehabilitation Center is pleased to announce its designation as the

Traumatic Brain Injury Model System of Mississippi

— one of seventeen designated sites in the Country — by the National Institute on Disability and Rehabilitation Research

PROJECT DIRECTOR

Mark Sherer, Ph.D., ABPP
Director of Neuropsychology Services

PROJECT MEDICAL DIRECTOR

Stuart A. Yablon, M.D.
MMRC Brain Injury Program Director



MISSISSIPPI METHODIST REHABILITATION CENTER
1350 East Woodrow Wilson, Jackson, Mississippi 39216
Telephone 601 981-2611, 1-800-223-6672
www.mmrcrehab.org

Coding Concepts

Q. In an article appearing in Coding Concepts regarding partial hospitalization of a psychiatric patient, you stated for a patient admitted to a psychiatric partial hospitalization program it would be appropriate to use codes 99221 -99223. What codes should be used to report subsequent visits for patients in this setting?

A. Codes 99221 - 99223 are to be used for the admission of the patient to a partial hospitalization setting. To report any subsequent services, you may use either the evaluation and management codes for subsequent daily care **(99231-99233)** or the psychiatric codes for inpatient services **(90816 - 90822)**.

To report the discharge of a patient in a partial setting, as a psychiatrist you have the option of using a subsequent daily hospital service code, a psychotherapy code based on the time and service involved or the hospital discharge codes (**99238,** 30 minutes of less or **99239**, more than 30 minutes

Q. In our office we see patients referred for neuropathy pain from lumbar disc bulging or herniation for supervised lumbar traction for 20 to 30 minutes, four to five times a week. Please advise the appropriate diagnosis and treatment codes to report these services.

A. Codes to report this type of treatment would be based on how the treatment was applied. There are two codes that could be used for this service based on the application of the treatment and the type of supervision provided during the treatment.

97012 Application of a modality to one or more areas, traction, mechanical

97122 Therapeutic procedure, one or more areas, each 15 minutes, traction manual

Both of these codes may be used to report services provided by either a physician or a qualified therapist. Carriers may have limitations or restrictions on who may provide the service as dictated by state requirements for who may provide a service.

Code 97012 is a supervised service that does not require direct (one on one) patient contact by the provider. The force used to create the tension is controlled through the amount of force or pounds allowed, duration of the treatment, and angle of degrees or pull. This may be intermittent or static (the length of time the traction is applied) or auto traction (use of the body's own weight to create the force).

Code 97122 requires the constant attendance or direct (one-on-one) contact with the patient by the provider of the service. This code requires the documentation of the actual time sent face-to-face with the patient. The report unit of service would be based on full 15 minute increments or intervals - not partial time. This code is the exertion of a pulling force to maintain proper position and to facilitate healing. Since this is a time-based code, the documentation should include the actual time spent applying the application. This form of traction is mostly used in cases involving fractures, dislocations, or muscle spasms.

Q. Regarding the above scenario, what ICD-9-CM codes should be used when reporting these services?

A. As with all diagnosis coding, the appropriate **ICD-9-CM** codes would be based on the reason for the treatment. For example to report problems involving a lumbar disc, you have a series of codes in the **722** category based on the specific problem (e.g., lumbar herniation **722.10** or bulging or protruding disc **722.2**). Documentation should clearly state the medical necessity or reasons for the service.

CODING TIP

For any service provided to a patient, the medical necessity for the service must be indicated or implied in the documentation? Diagnosis should be coded to the highest levels of certainty.

Do you have a question you would like answered in the Journal? Send your inquires to Wanda L. Adams, CPC, Adams & Associates, 3280 Lupine Drive, Arnold, MO 63010. Please include your name and phone number should additional information be required.

Wanda L. Adams, CPC, is owner and president of Adams & Associates, a health care consulting firm. She is a senior health care consultant and published author. She currently serves on the National Advisory Board of the AAPC and the Editorial Panel of Code Facts, a Medicode publication.



Michael H. Carter, Jr., M.D.

The President's Page

"You Don't Get the Breaks Unless You Play With the Team"

There are a couple of medical specialty societies in our state that have elected a president and/or other officers who do not belong to MSMA. This concerns me because we at MSMA work hard to be inclusive. We always try to include physicians from all parts of the state and with all types of interests to serve on councils, committees and the Board of Trustees. When we ask a specialty society president to serve on a committee or to nominate a member to represent that specialty's interests, it is disheartening to find out that we are asking a non-MSMA member to participate in or recommend a doctor to participate in an MSMA initiative.

This is just not right.

If you want to play on the team you have to dress out. That means that your state level specialty society officers should also be qualified to represent the society for MSMA. Otherwise, your specialty society is being led by a doctor who doesn't know what the broadest-based physician organization in the state is planning or has already done. And MSMA is forced to make decisions without input from the doctors in your specialty.

Today I'm issuing a challenge. Check with your specialty society leaders. If they are not members of MSMA ask them to join. Emphasize the need for your specialty society to be included in such MSMA activities as the legislative liaison team and to coordinate activities at the next annual session. Explain why your specialty should be consulted on important topics like changes to the Medicaid physician fee schedule, bills before the legislature, what will be discussed at upcoming meetings and who the speakers will be.

Together we can build a winning force.

Mike Carter

MSMA Co-sponsors "Building Mississippi's Inclusive Trauma Care System"

About 200 health care professionals throughout the state met September 10 in Jackson, for a day-long discussion of the development of the trauma care system. "Building Mississippi's Inclusive Trauma Care System," sponsored by the Mississippi State Medical Association (MSMA), the Mississippi Hospital Association (MHA) and the Mississippi State Department of Health (MSDH) gave health care experts a forum for forming plans for a statewide trauma response system. Speakers from Mississippi and other states addressed the past and future of trauma care in the state as well as the responsibilities, goals, and objectives for groups throughout the trauma care continuum. Throughout the discussion, all participants reiterated the themes of teamwork and equipping in meeting the need for and the goals of the system.

Chairman of the Department of Surgery at St. Joseph Hospital and Medical Center in Patterson, New Jersey, Frank Ehrlich, M.D., presented "Responsibilities, Goals and Objectives for Hospital and Medical Staffs." Executive Director, Sierra-Sacramento Valley Emergency Management Service Agency in Loomis, California, Leonard Inch presented "Responsibilities, Goals and Objectives for Pre-Hospital Providers."

Other panelists included: Marshall Tucker, senior vice president, Forrest General Hospital, Hattiesburg Medical Center; Jim Kirksey, M.D., emergency physician, North Mississippi Medical Center, Tupelo and Galen V. Poole, M.D., Department of Surgery, University Medical Center, Jackson.

"Health care is about improving the quality of life for all," said Lieutenant Governor Ronnie Musgrove at the recent meeting. "It takes more than one to make the trauma care system work; it takes funding and expertise to put it together. We must look past individual perspectives and look at the good of the state to improve the quality of life."

The 1988 Legislature passed the Trauma Care System Law to standardize trauma care through the state and reduce trauma's effects. State Health Officer Dr. Ed Thompson requested $6 million from the Joint Legislative Budget Committee to get the ball rolling. Last year, the Legislature came up with $1.5 million. Dr. Thompson said about $7.5 million a year is needed.

The law requires that an additional five dollars be assessed on all moving traffic violations, deposited into the state treasury as the Trauma Care Trust Fund, and appropriated annually to the State Board of Health. MSDH will administer the fund for state and regional trauma system administration, state trauma-specific public information and education plans, and hospital and physician Indigent Care Block Grant funding to MSDH-designated trauma centers.

The need is established in figures taken from the MSDH State Trauma Registry. In the state in 1997, there were over 200,000 emergency pre-hospital calls with trauma cases accounting for 23% of these calls. Trauma is the leading cause of death in people from 1 to 44 years of age with 82% of these injuries being unintentional.

MSMA, the MHA, and the MSDH announced they will form committees to help facilities assess needs and learn what's needed to be designated a trauma care center. Mississippi is the first state to implement a training program of this nature prior to the beginning of a trauma system. The goal of the training program is to prepare participants in all levels of the trauma system for upcoming system developments. "All participants play an important role and participants at every level of trauma care need to know what to expect in the coming months," Dr.

Thompson said.

No such statewide designation system exists. Some hospitals, such as the University of Mississippi Medical Center, have gone through the American Academy of Surgeons to obtain a Level 1 designation -- the highest rating. Two of the primary differences between Level 1 and 2 trauma centers are whether they are teaching facilities and if they have surgeons on site 24 hours a day.



The State Department of Health defines a trauma care system as "a continuum of care from initial injury detection through definitive care including rehabilitation and injury control." In line with this definition, a major focus of the meeting was the importance of each part of the continuum of care that will comprise the system.

State Emergency Management Services Director Wade Spruill, said a trauma system takes years to develop. "This is like our kickoff today," Spruill said. "But, we hope to see some movement in the next 12 to 18 months. Some hospitals haven't agreed to participate because they are unclear of what is expected." Spruill said hospitals need to know participation is voluntary. But, if they participate, they will be reimbursed for providing trauma care to people with no means to pay.

The goal of the system is to get the right patient to the right facility in the right amount of time in hopes that it will save lives and reduce injury severity. In his presentation, Spruill stated that with regard to the system, "It is the right time--we have the tools, we have financial assistance. It is the right thing to develop the trauma System. These are the right reasons- to reduce death/disability and prevent trauma events. It takes teamwork, but we will reach the system we want."

State Health Officer Ed Thompson said, "When we decided that we should attempt to develop a trauma care system in Mississippi, we knew that hospitals, doctors, and others could not afford to participate in a system if all the care they provided to those who could not pay went uncompensated. We also knew that we could not pay for all of the uncompensated care."

"We arrived at a solution to pay for part, about 30%, of the anticipated uncompensated care that would have to be rendered through the trauma care system. The estimated cost of providing this care is approximately $7.5 million and, through the Trauma Care Trust Fund, we have received allocation for $1.5 million. We still need to receive the remaining $6 million."

MSMA's New Headquarter's Construction Approved

The Executive Committee of the Board of Trustees has awarded Harrell Construction Company the contract to construct the association's new headquarters building on Highland Colony Parkway in Ridgeland. The building project is being managed by H.C. Bailey Company. The single story 12,400 square foot headquarters facility will be constructed on two lots in The Quorum, a small upscale office park which is being developed on the new Parkway by H.C. Bailey Company. The building is scheduled for completion in May, 1999.

MSMA Alliance Holds Fall Board Meeting



1998 Membership Committee Chair of the AMA Alliance ***Hope Grayson*** *(left) and MSMA Alliance President* ***Mrs. H. Allen (Cathy) Gersh.*** *Mrs. Grayson was the guest speaker at the September 10, 1998 Board meeting held at the Cabot Lodge North in Jackson. At the national level Mrs. Grayson has served as Field Director and two terms as chair of the Bylaws Committee.*



Left to right: AMA Alliance Health Promotion Committee Chair ***Mrs. William A. (Jeanne) Morrison,*** *MSMA Alliance President* ***Mrs. H. Allen (Cathy) Gersh,*** *1998 Membership Committee Chair of the AMA Alliance* ***Hope Grayson*** *and MSMA Alliance President-Elect* ***Mrs. Philip A. (Mary Helen) Schaeffer.***

MSMA Alliance President ***Mrs. H. Allen (Cathy) Gersh,*** *MSMA General Counsel* ***Linda McMullen*** *and MSMA Deputy Director, Director of Government Affairs* ***Charmain Thompson*** *review a grant proposal. The MSMA Alliance has applied for an educational grant from the "Partnership for a Healthy Mississippi" which is being funded by proceeds from Attorney General Mike Moore's lawsuit against the tobacco industry. The funds in the Partnership are specifically earmarked for educational programs on the dangers of tobacco use and are aimed at school children. The grant is being requested to expand the Alliance's award-winning Health Choice program for 5th and 6th graders, which includes components on alcohol, drug and tobacco usage. The grant request is for $54,000 over a two year period.*



UMC Medical Students' Auxiliary



Above photo, left to right: ***Shannon Warnock****, President, UMC Interns' and Residents' Alliance;* ***Gloria deShazo,*** *MSMAA sponsor;* ***Mary Sue Mitchell****, MSMAA hostess;* ***Cathy Gersh,*** *MSMAA president and* ***Laura Dyess,*** *UMC Students' Auxiliary President.*



Above photo, front row: ***Allison Rester,*** *membership chairman;* ***Debbie Copeland,*** *treasurer;* ***Neely Cooley,*** *hospitality chairman;* ***Abbie Morris,*** *publicity.* ***Back Row: Laura Dyess,*** *president;* ***Angie Baker,*** *corresponding secretary;* ***Sarah Atkinson,*** *second vice-president;* ***Chetta Mallette,*** *auxiliary board representative;* ***Melanie Mills,*** *recording secretary. Not pictured:* ***Deborah Smith,*** *first vice-president.*



Photo left, left to right: ***Jill Knight, Mary Booth, Karen Berch, Sharon Turner*** *and* ***Rebekah Cunningham.***

The UMC Medical Students' Auxiliary is a unique group bound together by the common thread of medicine which seeks to provide support, camaraderie, information, and entertainment during those often trying years of our spouses' training.

A successful welcome party set the tone for the 1998-1999 Medical Students' Auxiliary year. While "chilling out" at the homemade ice cream social at the home of Dr. and Mrs. John (Tammy) Cook, members were given the opportunity to meet new faces and renew old. Our first meeting of the year was held at the home of Dr. and Mrs. (Mary Sue) Don Mitchell. MSMAA President Cathy Gersh was our special guest for the evening. Members enjoyed wine and cheese as Mrs. Gersh and President of the Interns' and Residents' Alliance, Shannon Warnock, spoke about various projects sponsored by the state and residents' alliance.

A wide variety of activities has been planned for the remainder of the year. Our auxiliary will begin volunteer work with the UMC Children's' Hospital "Infant Care" program, and we are also planning a garage sale in the spring where proceeds will be donated to the children's hospital. We are also excited to have some special programs that will be led by Jackson's most talented. In November, Martha Collins will give a program about decorating for Christmas on a shoe string budget, and, in March, Felder Rushing and Julia Alien will demonstrate how to use accessories in your landscape with unique "yard art."

This is just a sample of the many exciting things our organization is planning for the year, and we look forward to joining the ranks of the MSMAA in the future.

-Laura Hartness Dyess, President,
UMC Medical Students' Auxiliary

UMC Interns' and Residents' Alliance Enjoys Fellowship



This year's "Alliance" group is larger than ever welcoming fifty members during a recent membership drive which culminated with a Bar-B-Que at the Mississippi Agricultural and Forestry Museum.



Mrs. Jim Fuller (Suzy) and her children, Jay, Lindsey, Kelsey and Caroline, had fun at this year's "Welcome Party" held at the Mississippi Agricultural and Forestry Museum.

The Interns' and Residents' Alliance is a spouse support group designed to foster closer relationships between the families of interns, residents and fellows during their residency programs at the University Medical Center (UMC). Residency can be a time of unique challenges and stress-filled days -- call schedules, missed dinners at home and emergency can make for zany hectic years! The common bond among physicians' spouses can truly help create friendships that will last for years to come.

This year's "Alliance" group is larger than ever welcoming fifty members during our recent membership drive culminating with our "Welcome New Members" Bar-B-Que at the Mississippi Agricultural and Forestry Museum. With a calendar offering something for everyone, the "Alliance" is composed of working women and stay-at-home mothers who both realize that medicine is an integral part of our lives. Alliance members are encouraged to treat membership like a cafeteria line and choose what most appeals to each. Highlights of this year include lots of "kidstuff" activities (for kids of all ages), social events (including cooking classes and combined socials with the UMC Students' Auxiliary, monthly Book Club and Bible Study meetings, and community service opportunities.

In keeping with the national AMA Alliance organization's service to the SAVE-A-Shelter program our



Some of this year's Alliance officers gathered at the home of Ann Dulske, hostess of the "New Members" Dinner. Left to right: ***Mary Ellen Stewart, Emily Pickell, Traci Martin, Suzy Fuller, Heidi York and Shannon Warnock.***

"Alliance" continues a tradition of service to Matt's House, a temporary shelter for homeless women and children in Jackson, Mississippi. By providing dinner each month for the residents and sponsoring a Christmas party for the resident families, our members are reminded of the blessings we have and the needs of others. Another community project supported by our members is the Reach Out And Read (ROAR) program designed to promote literacy among the pediatric patients at the Batson Childrens' Hospital at UMC. Volunteers share books with the children in the waiting room and talk with their parents about the importance of reading to their children. Both of these programs are as beneficial to our members as they are to those we serve.

A note of special thanks to the many members of the Central Mississippi Medical Alliance for their active support of our group during this last year. Several members have offered their support by providing suggestions for our community projects, funds to attend the AMA Alliance Annual meeting in Chicago, and two have even hosted us for dinner. Dr. and Mrs. (Cynthia) Michael Winkelmann hosted our Farewell Dinner this past spring and Dr. and Mrs. (Ann) Michael Dulske hosted this year's newest members in September. As always, we appreciate the continued support of the Central Mississippi Medical Alliance and its membership. Together we can make an impact in our community by promoting the good health of America and supporting the family of medicine.



The Interns' and Residents' Alliance gives both "young and old" an opportunity for fellowship. Several activities for children are held during the year.

-Shannon Warnock, President, UMC Interns' and Residents' Alliance

Meet the Staff

Linda McMullen, General Counsel



Years with company: new

Previous position: Prior to accepting the position of General Counsel with MSMA I practiced law with McFarlain, Wiley, Cassedy & Jones, P. A., in Tallahassee, Florida. I left government service early in 1984 to enter private practice with the firm and was voted a partner in 1986. I concentrated my practice on health care and insurance law, professional regulation and legislative representation. Prior to joining the firm I served as Counsel to then-Governor of Florida, Bob Graham, currently Florida's senior United States Senator.

Business philosophy: Few people do business well who do nothing else.

Favorite quote: "People learn by doing two things: reading and associating with smarter people."
–My Grandmother (paraphrasing Will Rogers)

Favorite books: "For Whom the Bell Tolls" by Ernest Hemingway, "Catch-22" by Joseph Heller, "Brave New World" by Aldous Huxley, "The Once and Future King" by T.H. White, and "A Confederacy of Dunces" by John Kennedy O'Toole.

Recently read: "Stones in the River" by Ursula Hegi, "Commanche Moon" by Larry McMurtry, "Caesar's Women" by Colleen McCullough, "Shipping News" by Annie Proulx.

Hobbies: Antique cars, golf, painting.

Family: My husband, Norbert Barbee, works for General Motors. His family has been in Jackson for several generations. I have one younger brother, Darrell, who lives in Tallahassee. He has two sons–Christopher, the eldest is currently serving on embassy duty in the U.S. Marine Corps and Heath, his younger brother is attending college in Tallahassee.

Hometown: I was born in Ft. Lauderdale, FL, when it was a small, rural community but moved away as a small child, subsequently living in several other cities in Florida and on Long Island in New York.

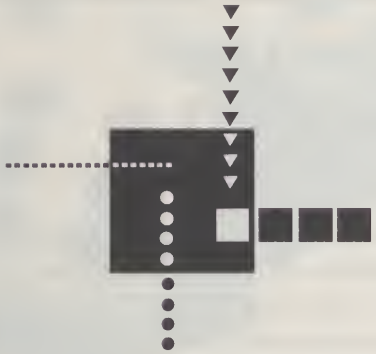
Dreams: To do a standing backflip, attend cooking school, to learn to use my fingers to whistle and travel to the Orient. I have given up on the standing backflip.

Most valued virtue: Integrity and a sense of humor.

Heroes: Thomas Jefferson, Julia Child and Roger Maris.

Key formative experiences: Taking my grandmother's advice and learning to read early and often, which encouraged me to continue my education, travel and always be willing to try new things.

Your Success is Our Goal



American Medical Association Organized Medical Staff Section (AMA-OMSS)* Assembly Meeting

December 3-7, 1998
Sheraton Waikiki Hotel
Honolulu, Hawaii

To succeed in today's health care environment, your medical staff needs good information and appropriate skills to meet the day-to-day challenges of medical practice. The OMSS can help. Attend this meeting and you will learn about:

- **Physician Compliance Program Implementation and Effective Operation**
- **The Critical Role of Physicians in Accountable Health Care Organizations**
- **1999 CPT and ICD-9-CM Coding Changes**
- **Improving Patient Care at the End of Life**
- **Key Legislative Issues for the 106th Congress and AMA Advocacy Efforts**

In addition to these educational offerings, as an AMA-OMSS representative of your medical staff, you can participate in policy-making and networking activities. **Our goal is to work with you to identify and address medicine's most pressing issues. We also want to help you increase your knowledge and leadership abilities so that together we can best serve patients, physicians, and the profession.**

To achieve our goal you can:

- Submit resolutions and participate in mode-of-practice and general interest forums to bring your concerns to the forefront.
- Testify at reference committee hearings and vote on actions in a democratic assembly to further AMA's advocacy agenda.
- Attend practical education programs to improve your medical practice, earn **4.5** hours of CME credit ** and pay no fee to register!

Your success depends on your involvement! Plan today to attend the 1998 Interim AMA-OMSS Assembly Meeting on December 3-7, at the Sheraton Waikiki Hotel. To receive more information and registration materials, please call **800 621-8335 and ask for the Department of Organized Medical Staff Services.**

* The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

** The AMA designates this educational activity for a maximum of 4.5 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

American Medical Association
Physicians dedicated to the health of America

"Life Preserver" Diabetes/Flu Campaign now being launched

The combination of two health care quality improvement projects, Outpatient Diabetes Management and Influenza Immunization, is represented in the "Life Preserver" Diabetes/Flu Campaign now being launched the Centers of Disease Control and Prevention (CDC).

The goal of this campaign is to get every patient with a diagnosis of diabetes a flu shot, with emphasis on the danger of influenza for persons with diabetes.

I.Q.H. has been actively promoting the influenza vaccination for Medicare beneficiaries for five years throughout the state with its Health Care Quality Improvement Project and the Horizons Project which concentrated on raising the low immunization rates in the African-American community. The Outpatient Diabetes Management Project, a relatively new emphasis in the Health Care Quality Improvement Department, is seeking to assess current practice patterns in diabetes management in the outpatient setting. The long-term objective is to modify practice patterns and processes of care to decrease morbidity and mortality of diabetics.

Persons with diabetes are about three times more likely to die with influenza and pneumonia than those without diabetes. Yet more than half of the persons with diabetes did not get the flu shot in a recent year—one statistic showed only 40 percent of persons with diabetes getting a flu shot. I.Q.H. joins with several organizations and numberous collaborators emphasizing the importance of influenza immunization, including the Health Care Financing Administration, the CDC and the State Department of Health.

In a recent release, Dr. Frank Vinicor, director of the Division of Diabetes Translation at CDC, pointed out, "People with diabetes may be unaware that the disease can make their immune system more vulnerable to severe cases or even death from the flu." The flu shot is an easy, safe, preventive measure that people with diabetes should take to protect themselves from risks associated with the flu.

Another emphasis for the diabetic population is the need for a pneumococcal polysaccharide vaccine to protect against the most common form of pneumonia because they are at greater risk for several comorbidity factors, including heart disease and renal failure. Annually, 10,000 to 30,000 persons with diabetes die from complications resulting from flu and pneumonia.

Nationwide, approximately 16 million people have diabetes, but half of them have not been diagnosed. New federally endorsed guidelines recommend for the first time that all adults be tested for diabetes by age 45. "These new guidelines will help us begin to diagnose many of the 8 million people who are unaware that they have diabetes,' according to Dr. Vinicor.

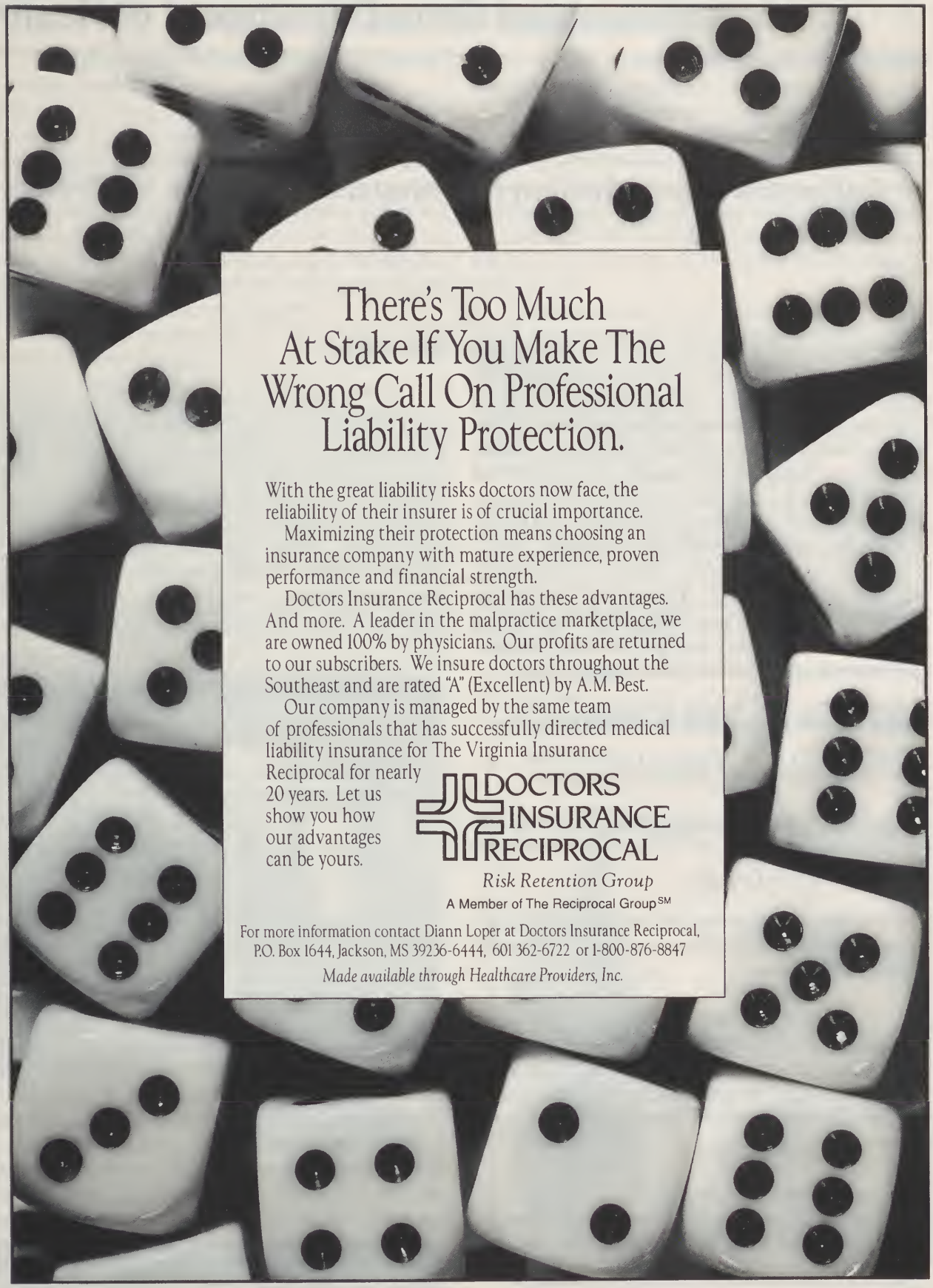
Educational materials are to be distributed through state health departments in line with the CDC's public service program called "With Diabetes, Prevention is Control," which includes radio and television broadcast and print public service announcements. Posters and brochures are available through this campaign. The brochures include a panel entitled "Ask Your Doctor," and urges patients to check with the physician about vaccines for preventing the flu and pneumococcal disease.

Facts worthy knowing, talking about, and acting upon concerning the flu-diabetes Life Preserve campaign:

- The Life Preserver campaign is an opportunity to put prevention into practice.
- African Americans have flu immunizations rates half those of whites; the burden is greater also with Mexican Americans.
- Diabetes is the seventh leading cause of death in this country.
- During flu epidemics, persons with diabetes are six times more likely than persons without diabetes to be hospitalized.
- Treating diabetes involves controlling blood glucose levels and having physician-directed monitoring of diet; establishing an exercise routine, and practicing preventive care.
- Individuals with diabetes are at increased risk for heart disease, blindness, kidney failure, and lower extremity amputations.

Anyone interested in the educational materials can contact I.Q.H. staff at 601-354-0304.

—James S. McIlwain, M.D., President


There's Too Much
At Stake If You Make The
Wrong Call On Professional
Liability Protection.
With the great liability risks doctors now face, the reliability of their insurer is of crucial importance.
Maximizing their protection means choosing an insurance company with mature experience, proven performance and financial strength.
Doctors Insurance Reciprocal has these advantages. And more. A leader in the malpractice marketplace, we are owned 100% by physicians. Our profits are returned to our subscribers. We insure doctors throughout the Southeast and are rated "A" (Excellent) by A.M. Best.
Our company is managed by the same team of professionals that has successfully directed medical liability insurance for The Virginia Insurance Reciprocal for nearly 20 years. Let us show you how our advantages can be yours.
DOCTORS INSURANCE RECIPROCAL
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For more information contact Diann Loper at Doctors Insurance Reciprocal, P.O. Box 1644, Jackson, MS 39236-6444, 601 362-6722 or 1-800-876-8847
Made available through Healthcare Providers, Inc.

Influenza Immunization Recommendations For 1997-98

Influenza and pneumonia comprise a leading cause of death in Mississippians 65 years of age and older, particularly in those with underlying chronic lung and/or heart disease(s). **People with other health problems, such as children who have cystic fibrosis or asthma, are also at greater risk of complications if infected with influenza. Even during non-epidemic years, some excess deaths occur. Influenza vaccine should be prioritized for persons in these high risk groups.** This is the single most important factor in preventing influenza-related mortality. **Though the vaccines are not 100% effective in preventing upper respiratory influenza infection, they may prevent lower respiratory tract involvement and other complications.**

Target Groups for Special Vaccination Programs

- Persons aged 65 years;

- Residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions;

- Adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including children with asthma;

- Adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies or immunosuppression (including immunosuppression caused by medications);

- Children and teenagers (aged 6 months - 18 years) who are receiving long-term aspirin therapy and therefore might be at risk for developing Reye syndrome after influenza;

- Women who will be in the second of third trimester of pregnancy during the influenza season. (Recent studies suggest that pregnancy may_ increase the risk of serious medical complications of influenza as a result of increases in heart rate, stroke volume and oxygen consumption; decreases in lung capacity; and changes in immunologic function. Also, pregnant women who have *medical conditions* that increase their risk for complications from influenza should be vaccinated before the influenza season - regardless of the stage of pregnancy);

Additionally, the following groups can transmit influenza to persons of high risk and should be candidates for vaccination:

- Physicians, nurses, and other personnel in both hospital and outpatient-care settings;

- Employees of nursing homes and chronic-care facilities who have contact with patients and residents;

- Providers of home care to persons at high risk (e.g., visiting nurses and volunteer workers); and

- Household members (including children) of persons in high-risk groups.

The common side effects of low grade fever, malaise, and myalgia after receiving flu vaccine can be largely prevented through use of a standard non-steroidal anti-inflammatory drug such as ibuprofen, acetaminophen or aspirin in standard dosages prior to, and for 24 hours after, receipt of influenza vaccine. Among children, febrile reactions may also be minimized by using only subvirion or purified-surface-antigen vaccines.

Annual Health Plan Process Begins

The Mississippi State Department of Health develops a State Health Plan each year under the authority of Section 41-7-173(s) and Section 41-7-185(g), Mississippi Code 1972 Annotated, as amended. The State Health Plan has three purposes: (1) to identify priority health needs in Mississippi;- (2) to recommend ways in which those needs can be met; and (3) to establish criteria and standards for health related activities which require Certificate of Need review. The Department includes public comment from the beginning of the development process through final adoption of the revised Plan.

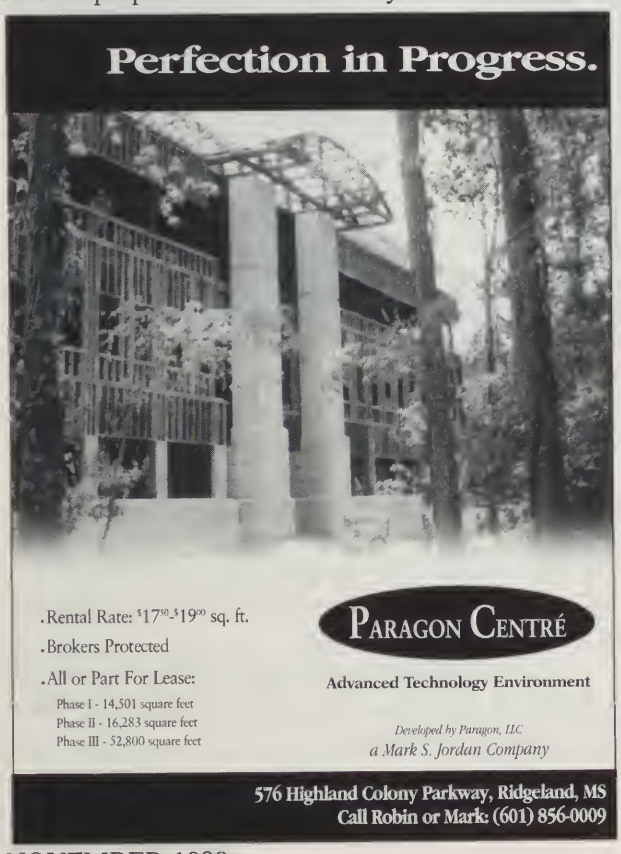
The process begins each fall with a public forum generally held before the State Board of Health at the Board's October meeting. At this forum, any concerned individual has an opportunity to make suggestions regarding any aspect of the Plan or propose changes to Certificate of Need (CON) criteria and standards. Anyone unable to attend the forum may submit written comments by mail. Staff of the Division of Health Planning and Resource Development study the comments and develop recommendations for any needed changes in CON criteria and standards.

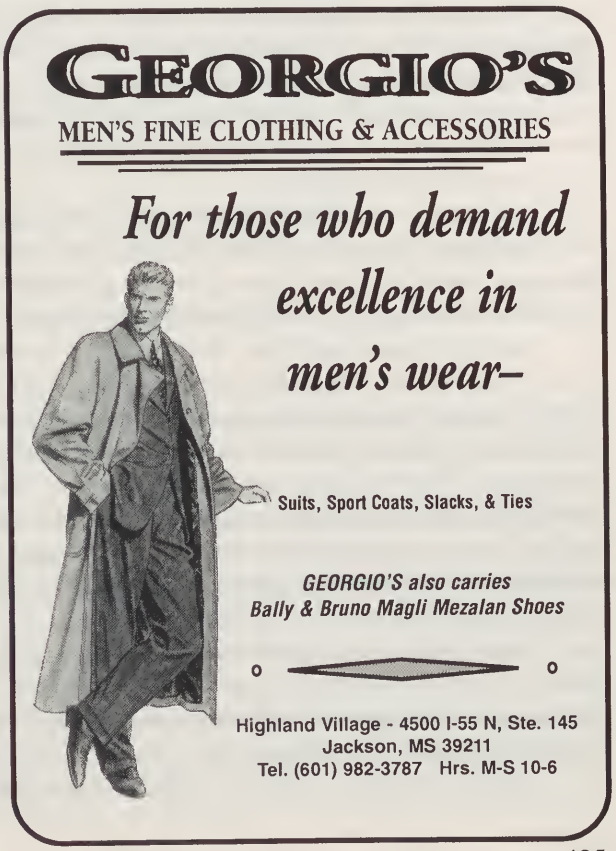
Each January, staff requests the Board of Health to approve an "intent to adopt" the proposed revisions and files the proposal with the Secretary of State. This action initiates a 30-day public comment period in accordance with Mississippi's Administrative Procedures Act.

The Department publishes proposed changes in a statewide newspaper, *The Clarion-Ledger*, mails a copy of all proposed changes to an established list of interested parties, and publishes the proposed changes in a monthly Department newsletter sent to more than 1,000 health care facilities, individuals, and organizations. The Department also provides the proposed changes to anyone who requests a copy.

Staff analyzes any comments received and incorporates them into proposed changes wherever possible. Staff presents final recommendations to the Board of Health at the April Board meeting each year. The Board approves or disapproves each proposed change and issues a "final adoption" of the revised Plan. The Department files the Plan as adopted with the Secretary of State.

Staff also obtains up to date statistical and general information from numerous departments of the MSDH, other state agencies, professional associations, and relevant organizations regarding every topic covered in the Plan. Staff compiles this information and produces a final Plan. Following approval by the Governor, the revised Plan becomes effective July 1 of each year.





UMC Medical Students Welcomed to Profession in New "Rite of Passage"

Lincoln McGinnis, 39, on his second day of medical school at the University of Mississippi Medical Center (UMC), is on his way to realizing a lifelong dream.

Older than many of his freshman colleagues in the School of Medicine Class of 2002, he was one of the 106 new medical students who got white coats in a Tuesday night ceremony.

In an event new to the Medical Center, medical students received the white coat and recited the Hippocratic oath at the beginning of their careers in medicine.

"The next time we recite this oath together will be in May of 2002 after you've received your diplomas," said UMC vice chancellor Dr. Wallace Conerly.

For McGinnis, the new ceremony and "the whole tone of orientation was very consistent with what I want to do in the practice of medicine.

McGinnis is interested in primary care where he can "build relationships with my patients." He's not certain yet which direction that will take. "We have a fivemonth old now, so naturally I've been thinking of pediatrics.

Benita Myles of Starkville is fresh from graduation at Ole Miss, but she's thinking of primary care, too. "I want to practice in a small town and be a real part of the community. I want my patients to be my friends as well as my patients." Myles says the ceremony makes her feel like a part of the medical profession right away. "I think, as a medical student, you're always on the outside looking in at the profession. I think this ceremony makes us feel like we're on the inside.

James Glisson of Corinth says in seven years he hopes he'll be establishing his practice in his hometown. "During our course in gross anatomy, I think it will help me to remember this ceremony.

Glisson and Lana Jackson of Meridian are both graduates of pharmacy school. Both got the chance to see the medical profession up close during their clinical rotation at the Medical Center and decided to pursue a career. Jackson is leaning toward internal medicine. "I will leave myself open to a subspecialty.



Helen R. Turner, M.D., Associate Dean for Academic Affairs, welcomes a medical student into his new community of learning with a white coat.

Dr. Richard deShazo, chairman of the Department of Medicine at UMC, spoke to the group before they received their white coats.

deShazo's Remarks

This is a true story: One Wednesday night, several years ago, I was sitting in the bass section at choir practice when a soprano, a high school teacher sitting next to my wife, tapped me on the shoulder and whispered that she wanted to talk to me later. After practice, she found me and we stepped aside to talk. I knew that she had had a lot of illness in her family lately, so I figured this would be a serious conversation. She told me that because of her family situation, she had attended the mini-medical school at the University to get some medical information. She was very impressed with the doctors she met there and their commitment to medical education and research. Then, she asked her question which I must say, startled me. As part of her retirement planning, she was considering donating her body to the Medical School for use in the Gross Anatomy course. She wanted to know if I thought this was a good decision. How would you have responded?

What Students Bring to Medical School?

Freshman medical students bring a great many good things with them to medical school. You are bright, well-educated and for the most part thoughtful, caring, empathetic individuals with a great desire to help people.

Why is it then that surveys repeatedly show that the general public thinks that graduate physicians are, as a group, "pompous, pedantic, insensitive,and condescending?"[1]

Several years ago, a group of physicians from Yale University wrote an interesting book, called Empathy in the Practice of Medicine. Beyond Pills and the Scalpel. One well known author explained this public perception by saying that "During medical education, we first teach the students science, and then we teach them detachment. To these barriers to human understanding, we later add the armor of pride and finish with the fortress of a desk to separate they learn to mask their feelings, or worse--to deny them. They learn detachment." This starts when "medical students begin their education with a dead body. Cadavers do not complain and no one has to listen. It is then that students first harden themselves to empathy."

The Difference Between a Clinical Scientist and a Doctor:

For the next two years, we will spend a great deal of time and energy assisting you to become a "clinical scientist". Becoming a clinical scientist is the central part to becoming a physician. You must understand the basic science that underpins our understanding and treatment of disease. This information will provide the foundation for the lifelong learning required to maintain your competence in medicine.

But, be aware that there are major differences between clinical scientists and doctors: [2]

1. A clinical scientist understands how physiological processes interact at a cellular level to produce disease. A doctor understands these processes. A doctor also understands how the disease effects the day-to-day life of his patient and how to assist the patient in adapting to those effects.

2. A clinical scientist is capable of optimal diagnosis and treatment of the disease. A doctor is similarly capable, but in the process establishes a relationship with the patient that is therapeutic beyond pills and scalpels.

3. A clinical scientist knows the psychological dynamic of client and customer relationships in the delivery of health care. The doctor also understands these dynamics, but knows that his relationship involves transactions beyond those which occur with clients or customers. Those with whom he establishes a professional relationship are more than these, they are his patients and his friends.

As Frances Peabody said, "The art of medicine and the science are not antagonistic, but complementary to each other. Good practice presupposes an understanding of the sciences which contribute to the structure of modern medicine, but it is obvious that sound professional

The Coat

So the presentation of this coat today is given to you as an encouragement and as a reminder.

For the next two years, you will spend most of your energies mastering the intricacies of clinical science. We want to encourage excellence in this endeavor as it is essential to your ultimate goal of becoming a physician. But when these efforts become overwhelming, look at your coat and remember that you are on the road to a noble calling.

The coat is a reminder of those values that brought you here in the first place. Nourish your humanity by learning to value your fellow students as future colleagues in the practice of medicine. Share your hopes and aspirations with them and encourage them. Give attention to the opportunities that will be provided to preserve and develop your humanistic skills.4,5 Value your teachers. Remember, your patients will come in all sizes, shapes, aptitudes and abilities as well. And value yourself. Don't become so obsessed with your studies and performance that you neglect to remain physically fit and in contact with the rest of the world.

Back to Choir Practice

So what do you think I said to my fellow choir member? After a period of speechlessness, I told her that we teach students to view their cadaver as their first patient. Out of that students treat cadavers with respect and have reverence for the spirit which once occupied the body. I know that will be the case with you and that is among the reasons I welcome you to the profession of medicine.

-Richard D. deShazo, M.D.
Professor of Medicine and Pediatrics
Chairman, Department of Medicine

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New Members

Baugh, Bradley R., Cleveland. Born Temple, TX, April 3, 1968; MD University of Texas Southwestern Medical School, Dallas, TX, 1994; ob-gyn residency, Parkland Hospital, Dallas, TX, 1994-98; member of Delta Medical Society.

Davenport, Charles W., Jr., Meridian. Born Meridian, MS, August 12, 1957; MD University of Mississippi School of Medicine, Jackson, MS, 1992; internal medicine residency, University Medical Center, Jackson, MS, 1992-95; cardiology fellowship, same, 1995-98; elected by East MS Medical Society.

Dugaw, John E., Ridgeland. Born Seattle, WA, June 2, 1945; MD University of Nebraska College of Medicine, Omaha, NE, 1971; family practice residency, Same, 1971-75; geriatrics fellowship, Stanislaws Medical Center, Modesto, CA, 1975-77; elected by Central Medical Society.

Dungan, V. Craig, Meridian. Born Jersey Shore, PA, December 4, 1962; MD University of Mississippi School of Medicine, Jackson, MS, 1990; internal medicine residency, Vanderbilt University Hospital, Nashville, TN, 1990-93; gastroenterology/hematology fellowship, LSU Medical Center, Shreveport, LA, 1995-97; elected by East MS Medical Society.

Duplantis, Allen J., Meridian. Born Houston, TX, July 6, 1949; MD University of Texas Health Science Center, San Antonio, TX, 1975; internal medicine residency Brooke Army Medical Center, San Antonio, TX, 1976-78; cardiology fellowship, Same, 1978-80; elected by East MS Medical Society.

Gorman, Richard J., Biloxi. Born Chartes City, IA, January 30, 1943; DO, Kansas City School of Health Sciences, Kansas City, MO, 1972; pediatric residency, Keesler Medical Center, KAFB, MS, 1974-77; neurology fellowship, University of Alabama Medical Center, Birmingham, AL, 1978-81; elected by Coast Counties Medical Society.

Heck, Donald V., Jackson. Born Florence, AL, June 29, 1966; MD Duke University School of Medicine, Durham, NC, 1993; radiology residency, Washington Univ. Medical Center, St. Louis, MO, 1993-97; fellowship interventional radiology, Same, 1997-98; elected by Central Medical Society.

Holy, James W., Jackson. Born Jackson, MS, July 29, 1959; MD University of Mississippi School of Medicine, Jackson, MS, 1993; anesthesiology residency, Richland Memorial Hospital, Columbia, SC, 1995-98; elected by Central Medical Society.

Horsley, W. Stewart, Jackson. Born Tuscaloosa, AL, July 6, 1963; MD University of Alabama School of Medicine, Birmingham, AL, 1989; general surgery residency, Emory University Hospital, Atlanta, GA, 1989-94;cardiothorafcis surgery residency, Same, 7/95 – 6/98; elected by Central Medical Society.

Jones, Robert H., Columbus. Born Shawnee, OK, March 14, 1967; MD University of Texas Southwestern Medical School, Dallas, TX, 1993; radiation oncology residency, Medical College of Wisconsin, WI, 1993-98; elected by Prairie Medical Society.

C. Ken Lippincott, Tupelo. Born Grenada, MS, March 8, 1954; MD Tulane University School of Medicine, New Orleans, LA, 1980; psychiatry residency, same, 1980-85; elected by Northeast MS Medical Society.

Lock, James W., Jackson. Born Brandon, MS, December 11, 1954; MD Meharry Medical Medical College School of Medicine, Nashville, TN, 1989; internal medicine residency, University Medical Center, Jackson, MS, 1989-92; elected by Central Medical Society.

McCloud, Miyako, Meridian. Born St. Louis, MO, January 4, 1967; MD Rush Medical College, Chicago, IL, 1995; family medicine residency, Henry Ford Hospital, Detroit, MI, 1995-98'; elected by East MS Medical Society.

McMullan, Michael R., Jackson. Born, Union, MS, December 15, 1964; MD, University of Mississippi School of Medicine, Jackson, MS, 1991; internal medicine residency, University Medical Center, Jackson, MS, 1991-95; cardiology residency, same, 1995-97; cardiology fellowship, Duke University Medical Center, Durham, NC, 1997-98; elected by Central Medical Society.

Method, Michael W., Lucedale. Born Chicago, IL, January 20, 1960; MD Northwestern University Medical School, Chicago, IL, 1986; ob-gyn residency, David Grant USAF Medical Center, Travis AFB, CA, 1986-90; gynecologic oncology fellowship, University of Miami Medical Center, Miami, FL 1993-96; elected by South MS Medical Society.

Mire, Blane A., Natchez. Born Lafayette, LA, September 9, 1966; MD Louisiana State University Medical School, Baton Rouge, LA, 1995; internal medicine residency, Earl K. Long Hospital, Baton Rouge, LA, 1995-98; elected by Homochitto Valley Medical Society.

Robinson, Herbert G., III. Born Monroe, LA, December 17, 1966; MD University of Mississippi School of Medicine, Jackson, MS, 1994; family practice residency, University Medical Center, Jackson, MS, 1994-97; elected by Singing River Medical Society.

Romanucci, Eric, Jackson. Born Albany, NY, February 19, 1965; MD Eastern Virginia Medical School, Norfolk, VA, 1992; general surgery residency, State University of NY, Buffalo, NY, 1992-97; colon & rectal surgery fellowship, Louisiana State University Medical Center, Shreveport, LA, 1997-98; elected by Central Medical Society.

Schmidt, Richard A., Biloxi. Born New Orleans, LA, December 8, 1939; MD Tulane University School of Medicine, New Orleans, LA, 1964; pediatric residency, University of Tennessee Medical Center, Memphis, TN, 1965-66 and 1968-69; elected by Coast Counties Medical Society.

Tanious, Aremmia D., Laurel. Born Egypt, July 24, 1961; MD University of Assuit School of Medicine, Egypt 1984; medicine internship, LaGuardia Hospital, NY, 1994-95; neurology residency, University of Kentucky Medical Center, Lexington, KY 1995-96 and University of South Alabama Medical Center, Mobile, AL, 1996-98; elected by South MS Medical Society.

Urban, Laura L., Jackson. Born Houston, TX, May 24, 1968; MD East MS State University Medical School of Medicine, Johnson City, TN, 1994; ophthalmology residency, University Medical Center, Jackson, MS, 1994-98; elected by Central Medical Society.

DEATHS:

Peden, Richard L., Gulfport. Born Feb. 8, 1948; DO University of Health Sciences College of Osteopathic Medicine, Kirksville, Missouri, 1977; Board Member of MS State Board of Medical Licensure; died August 16, 1998, age 50.

Stockton, Wendell H., Amory. Born Sept. 24, 1998; MD University of Tennessee College of Medicine, Memphis, Tn, 1947; practiced pediatrics in Amory for over 50 years; died Sept. 4, 1998, age 73.

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Dwalia South, M.D., of Ripley, was elected president-elect of the Mississippi Academy of Family Physicians.

Stanley D. Hartness, M.D. was recognized as Family Physician of the Year by the Mississippi Academy of Family Physicians.

Dennis Morgan, M.D., medical oncologist, began a new practice in Oxford on September 1. Dr. Morgan is on staff at Baptist Memorial Hospital-North Mississippi, Oxford.

Felix H. Savoie, III, M.D. recently gave 5 scientific presentations at the VI Congreso Argentino De Arthroscopia III Encuentro Latino Americano in Buenos Aires, Argentina. His talks were entitled "Arthroscopic Rotator Cuff Repair", "Shoulder Arthroscopic Management of Multidirectional Instability", "Arthroscopic Management of Lunotriquetral Instability", "Diagnostic Elbow Arthroscopy", and "Arthroscopic Management of Arthritis of the Elbow."

Judith Gearhart, M.D., associate professor of family medicine, was honored for outstanding achievement in the field at the American Academy of Family Physicians meeting in San Francisco, California. Dr. Gearhart accepted the 1998 Exemplary Teaching Award for Part-Time Faculty. The award recognizes academy members for their excellence in teaching as well as those who have implemented outstanding educational programs and developed innovative teaching models. One national award is presented each year in three separate categories: full-time faculty, part-time faculty and volunteer faculty. This is the second consecutive year that a University Medical Center faculty member has received the part-time faculty award. **Dr. Thomas Davis, M.D.,** clinical associate professor of family medicine, was the 1997 recipient of the award.

William B. Geissler, M.D., Associate Professor of Orthopaedic Surgery, Division of Hand and Upper Extremity Surgery, and Chief of Arthroscopy and Sports Medicine at the University of Mississippi Medical Center, recently participated in a symposium entitled "Use and Abuse of Wrist Arthroscopy" at the 53rd annual meeting of the American Society for Surgery of the Hand in Minneapolis, MN. His topic was "Expanding the Bounds of Wrist Arthroscopy". He was also a panel participant on the symposium on the management of distal radius fractures, including a live surgical demonstration. Dr. Geissler was also faculty for the combined American Academy of Orthopaedic Surgeons and the American Society for Surgery of the Hand, combined basic and advanced wrist arthroscopy course recently held in Chicago, Illinois. He spoke at the basic and advanced course on arthroscopic management of distal radius fractures.

Barry G. Munn, M.D. has joined Weatherly Sports Medicine and Family Orthopaedic Clinic in the practice of Orthopaedic Surgery.

Paul White, M.D., FACP, an internal medicine physician in private practice with Tupelo Medical Group, has been elected a Fellow of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM). The distinction recognizes achievements in internal medicine, the specialty of adult medical care.

William Causey, M.D., a physician at Jackson Medical Clinic and a member of Baptist Health Systems' HIV/AIDS patient care team was recently honored with HIV/AIDS Outstanding Service Award for his work with HIV/AIDS patients. The award was presented to honor those who have provided outstanding contributions in HIV/AIDS care services, advocacy and prevention.

Chris H. Benson, M.D., a rheumotologist at Hattiesburg Clinic, recently completed the requirements for certification as a clinical densitometrist. Densitometry enables physicians to measure bone strength to diagnose and treat osteoporosis and other metabolic bone diseases.

The Journal MSMA Personals Column publishes short items on awards, honors, elections, and other noteworthy events and accomplishments about physicians. We encourage the membership to send notices to: Personals Column, Journal MSMA, PO Box 5229, Jackson, MS, 39296-5229 or fax to 352-4834.

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The Mississippi State Department of Health is seeking qualified candidates for the position of Physician, Senior, Office Director for the Office of Personal Health Services, in Jackson, MS. This position is responsible for the following areas: • Directing an office within the State Department of Health that has approximately 200 employees and an operating budget of approximately $57 million. • Planning, conducting, and supervising through subordinate staff, programs aimed at improving the health status of women, infants, and children throughout the state (maternal-child health, family planning, child health, children with special health care needs, and WIC). • Rendering consultative services in maternal-child health matters to public officials, voluntary health agencies, committees, other professional health care providers, and various other health care organizations. • Utilizing epidemiological and other surveillance methodologies in planning public health initiatives and consultation, in preparing reports, and in making public presentations.

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Information For Authors

The Journal of The Mississippi State Medical Association welcomes material for publication if submitted in accordance with the following guidelines. Address all correspondence to the Editor, Journal of the Mississippi State Medical Association, P.O. Box 5229, Jackson, MS, 39296-5229. Contact the managing editor with any questions concerning these guidelines.

Manuscripts should be of an appropriate length due to the policy of the Journal to feature concise but complete articles. (Some subjects may necessitate exception to this policy and will be reviewed and published at the Editor's discretion.) The language and vocabulary of the manuscript should be understandable and not beyond the comprehension of the general readership of the Journal. The Journal attempts to avoid the use of medical jargon and abbreviations. All abbreviations, especially of laboratory and diagnostic procedures, must be identified in the text. Manuscripts must be typed, double-spaced with adequate margins. (This applies to all manuscript elements including text, references, legends, footnotes, etc.) **The original and one duplicate should be submitted.** The Journal will also accept manuscripts in the form stated above on IBM-compatible floppy diskette. If a diskette accompanies the manuscript, please identify the word processing program used and the file name. Pages should be numbered. An accompanying cover letter should designate one author as correspondent and include his/her address and telephone number. Manuscripts are received with the explicit understanding that they have not been previously published and are not under consideration by any other publication. Manuscripts are subject to editorial revisions as deemed necessary by the editors and to such modifications as to bring them into conformity with Journal style. The authors clearly bear the full responsibility for all statements made and the veracity of the work reported therein.

Reviewing Process. Each manuscript is reviewed by the Editor and/or Associate Editor. The acceptability of a manuscript is determined by such factors as the quality of the manuscript, perceived interest to Journal readers, and usefulness or importance to physicians. Authors are notified upon the acceptance or rejection of their manuscript. Accepted manuscripts become the property of the Journal and may not be published elsewhere, in part or in whole, without permission from the Journal.

Title Page should carry [1] the title of the manuscript, which should be concise but informative; [2] full name of each author, with highest academic degree(s), listed in descending order of magnitude of contribution (only the names of those who have contributed materially to the preparation of the manuscript should be included); [3] a one- to two-sentence biographical description for each author which should include specialty, practice location, academic appointments, primary hospital affiliation, or other credits; [4] name and address of author to whom requests for reprints should be addressed, or a statement that reprints will not be available.

Abstract, if included, should be on the second page and consist of no more than 150 words. It is designed to acquaint the potential reader with the essence of the text and should be factual and informative rather than descriptive. The abstract should be intelligible when divorced from the article, devoid of undefined abbreviations. The abstract should contain: [1] a brief statement of the manuscript's purpose; [2] the approach used; [3] the material studied; [4] the results obtained. Emphasize new and important aspects of the study or observations. The abstract may be graphically boxed and printed as part of the published manuscript.

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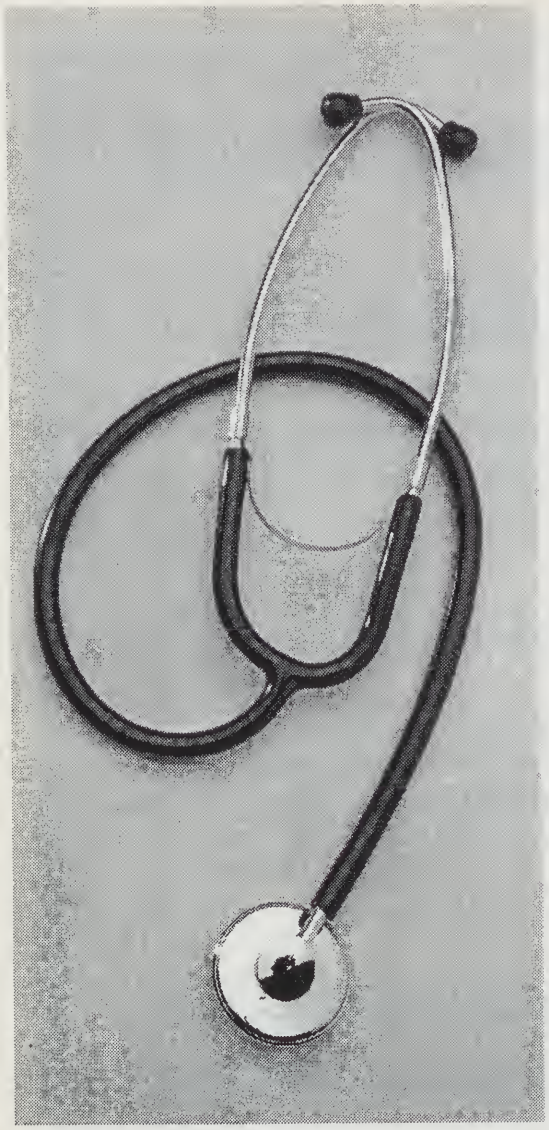
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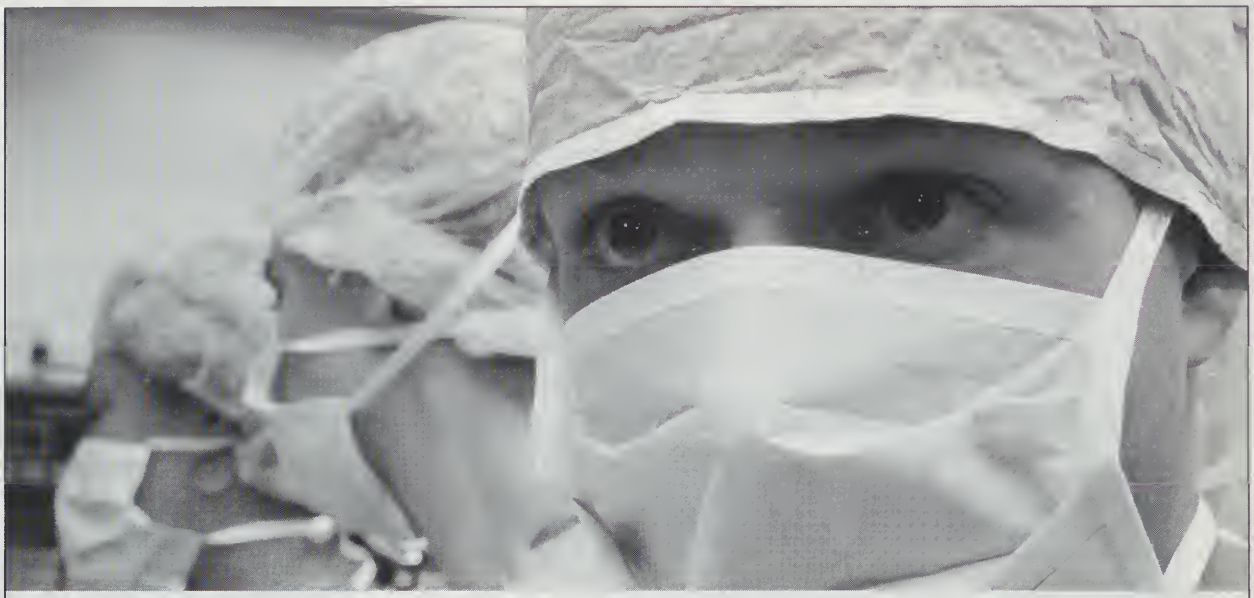
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Introducing Evidence-Based Medicine into a Community Family Medicine Residency

Ann F. Kenney, M.D.

ABSTRACT:

In this article we discuss how we are introducing the concept of evidence-based medicine (EBM) into our Family Practice Residency Program. We review the basic concepts of EBM., show how these have been incorporated in the curriculum, and how they are applied to patient care. We identify the need for further work to evaluate our efforts and improve them.

Key word: Evidence-based medicine; teaching; family medicine.

Our residence program, started in 1995, is community-based and is affiliated with the University of Mississippi School of Medicine. The program is part of the North Mississippi Medical Center which includes a 650 bed rural hospital {the largest non urban hospital in the country} and a wide network of primary care and speciality services encompassing 23 counties in northeast Mississippi. A mandate of our program is to produce primary care physicians for the under serviced rural areas of northeast Mississippi, and adjoining areas of Alabama and Tennessee. The residents attending our program had, for the most part, no exposure to the concept of evidence-based medicine in their undergraduate medical curriculum.

DEFINITION

Evidence-based medicine (EBM) has been defined by Sackett et. al.[1] as "the conscientious and judicious use of the current evidence from clinical care research in the management of individual patients." It is a culmination of the move from a practice based on pathophysiology and accumulated clinical experience to a practice based on large randomized controlled clinical trials which evaluate outcomes that are of significance to patients (i.e. morbidity, mortality and quality of life). Cost and patient preference are also considered of significance.

According to Sackett and Rosenberg[2], EBM comprises five interrelated concepts: 1) medical decisions should be based on the best available evidence, 2) the patients' problems should dictate the nature of the information sought, 3) in order to identify and interpret the evidence the practitioner must understand epidemiology and biostatistics as well as pathophysiology, 4) the knowledge gained from the examination of research must be translated into clinically relevant interventions for our patients, and 5) our practice of these interventions should undergo constant evaluation and revision.

It is no longer adequate to pack a finite amount of knowledge into the heads of our residents in the course of their training, and hope that it will last them for the

rest of their career. Information in the medical field is exploding. Rosser and Shafir[3] state that there are approximately 400,000 new entries added to the National Library of Medicine MEDLINE database each year. They estimate that a practitioner would need to read 6000 articles a day to keep abreast of the burgeoning knowledge in the field of medicine. This dilemma is particularly apparent for primary care practitioners whose domain covers a breadth of health care issues from the cradle to the grave. Training in an evidence-based approach to medical knowledge should teach new physicians to ask the right question, efficiently perform literature searches of high-yield sources, critically appraise the information with regard to its validity, reliability, and generalizability, and apply the lessons to clinical care.

In the era of managed care EBM skills are obligatory. Physicians are being asked to evaluate and apply clinical care guidelines in every field of medicine in order to decrease the incidence of ineffective, inappropriate and potentially harmful practices, and to control rising health care costs without jeopardizing quality.[4] Knowledge of how to access EBM resources is especially important for rural primary care practitioners whose remote location may limit their access to other sources of information.

The goal of residency education is no longer to turn out a finished product, but rather a physician who knows how to learn. To this end we initiated an effort to introduce the concept of EBM to our residence program.

EBM CURRICULUM

While EBM has been discussed since the 1970's, it is moving from the academic journals to popular use in this decade. There is need for curricula in EBM for Family Medicine residency programs.[5] We identified several areas where EBM could be introduced into our program. First, residents need to know where to find information efficiently, and to have access to this information in a convenient way. We are developing a resource base in our residency clinic that incorporates key sources of high quality information including both primary sources and predigested material such as Evidence-Based Medicine and ACP Journal Club. Our core curriculum includes sessions in the hospital computer laboratory on how to do literature and Internet searches, and the residency clinic is equipped with Internet MEDLINE and Cochrane Collaboration database access for faculty and residents.

Secondly, the curriculum includes education in how to efficiently identify credible, clinically important information and how to critically appraise this literature. Residents are taught basic concepts of statistics, population-based medicine and research. This has been organized by providing residents with a notebook containing the series of articles "Information Mastery"[6], "Users Guide to the Medical Literature"[7], and "The Rational Clinical Exam"[8] which have appeared in the Journal of the American Medical Association over the past several years. We believe that physicians may feel intimidated by the statistical and epidemiological concepts in medical research. The above mentioned articles have demystified these concepts and present them in an accessible form. We hope that with practice, residents will gain confidence in critical appraisal skills and will use them routinely and with ease.

Finally, the residents are encouraged to develop their own system of information storage and retrieval, either through a filing system or electronically.

APPLICATION TO PATIENT CARE

The key aspect of an evidence-based approach to medicine centers around patient care. We have encouraged our residents to use their skills in EBM in their clinical work. They learn to generate questions from problems that arise during morning rounds on inpatients and in the outpatient clinic, and to seek evidence-based solutions. This is reinforced in the didactic teaching in which the results of randomized-controlled trials in areas such as lipid lowering medication, hypertension, and heart disease are presented and interpreted.

As well, each resident is required to develop a clinical care guideline for a common family practice problem, based on a survey of the top twenty-five diagnoses in the Family Medical Clinics in our hospital system. The guidelines are grounded in evidence-based research and applied to the particular conditions of our area. Guidelines developed to date include acute pharyngitis, asthma management in children, bronchitis, otitis media and sinusitis.

EBM skills are also honed in a monthly journal club where residents alternate analyzing articles following the framework in the "Users Guide to Medical Literature." They are joined in the Journal Club by faculty members, a research Ph.D., and a Pharm.D. medical writer.

Finally, residents are encouraged to develop research projects in which they can have first hand experience with the process behind the evidence. Present undertakings include developing an acute care plan for the management of pharyngitis to be "detailed" to the Family Medicine Clinics. We have also initiated projects involving patient education, adolescent medicine and maternal-child health.

We have plans to further develop our evidence-

based approach to residency teaching. We intend to develop and refine the teaching methods and tools to make them practical, problem-based, accessible and even fun! We need to evaluate the effect of our interventions by finding ways to measure the residents' competencies in EBM skills and to see if these improve in response to our teaching. As well we can follow the residents after graduation and see if they maintain their skills over time. Finally, the most important results of all are patient outcomes. If teaching primary care practitioners to base their care in the best available science can improve outcomes for patients, then we have a worthwhile accomplishment.

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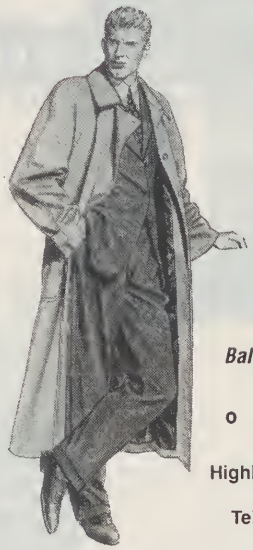
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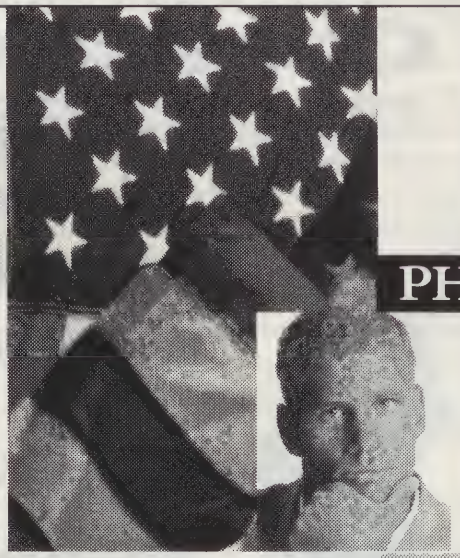
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Functional Endoscopic Sinus Surgery: Results in the Young Child

James R. Haltom, M.D.
C. Ron Cannon, M.D.

ABSTRACT

Recent studies have addressed the usefulness of functional endoscopic sinus surgery (FESS) in both adult and pediatric patients, but little information is available concerning the long-term followup of young children. During a 31 month period, 57 children, age six years or less had FESS performed by a single surgeon. In each case the child had failed aggressive medical management including long-term oral antibiotics. A coronal sinus CT scan was obtained prior to surgery and showed opacification of the maxillary and/or ethmoid sinuses with obstruction of the ostiomeatal complexes. A similar surgical approach was used in each case. There were no major surgical or anesthetic complications noted during the initial procedure or the followup debridement.

To evaluate the results of FESS, a questionnaire was mailed to the parents of each patient. The questionnaires were completed 5 to 36 months after surgery (mean 17.3 months). Ninety-three percent of the children showed improvement based on the observations of their parents. Improvement was judged primarily by reduced symptoms, reduced need for antibiotics, and the need for fewer doctor visits during the followup period.

In summary, FESS appears to offer a safe and effective technique to control sinus disease in children who do not respond to aggressive medical management. In skilled hands, this technique is associated with few complications and appears to offer relief even in young patients.

INTRODUCTION

During the last decade, tremendous strides have been made in our understanding of pediatric sinusitis.[1,2,3,4,5] In the past this disease often went undiagnosed, since plain sinus x-rays can miss considerable disease. More recently, the general availability of the CT scanner has greatly increased our ability to diagnose sinusitis in children.[6,7] Likewise, the common bacteriologic causes in this age group have been determined.[8,9,10] Most children respond well to medical management with appropriate antibiotics, but some do not improve and may be candidates for surgery. Until recently, children, especially young ones, were often not considered for sinus surgery. The development of functional endoscopic surgical techniques allows a more physiologic approach to many patients with infected sinuses unresponsive to medical treatment.[11,12,13] These surgical techniques are now being used to treat younger patients.[14,15,16] This paper will examine the followup of 57 preschool age children operated on for chronic sinusitis that did not resolve with aggressive medical therapy.

METHODS

During a 31 month period, 57 children between the ages of 13 and 75 months (mean of 36.7) had functional endoscopic sinus surgery performed for medically unresponsive sinusitis. There were 38 males and 19 females. The patients were referred to a single surgeon (C.R.C.) after failing treatment with long-term antibiotics and other ancillary therapy, such as decongestants and intranasal steroids. The children's symptoms included nasal congestion, post-nasal drainage, mouth breathing, malodorous breath, discolored rhinorrhea, and malaise. These symptoms had been present for months prior to surgery. Each child had a coronal sinus CT scan before surgery

The CT scans showed maxillary sinusitis and ethmoid disease, with obstructed ostiomeatal complexes (Fig 1A and 1B). None of the children had any known associated medical problems such as cystic fibrosis, hypogammaglobulinemia, or dysmotile cilia syndrome. Due to the age of the patients and variety of physicians engaged in evaluation and followup, allergy testing was not obtained in all patients. Following surgery, a parental survey was performed to determine outcome. The surveys were performed 5 to 36 months after the surgery (mean of 17.3 months).

SURGICAL TECHNIQUE

Using instruments developed for pediatric patients, the affected sinuses were approached using a transnasal endoscopic approach. Visualization for the majority of the procedure was provided by a O degree, 4 mm rigid telescope. A dual suction system, consisting of a curved suction as well as a #5 straight suction tip, was used. Pediatric straight angle and right angle pituitary forceps were invaluable in removing diseased mucosa (Fig.2).

A small sickle knife was used to make an incision in the area of the ethmoid infundibulum (Fig.3). After entering the ethmoid sinus, care was taken to avoid the orbit laterally and the cribriform plate superiorly. Once the diseased mucosa was removed from this area, the maxillary sinuses were entered. Since the maxillary sinus ostia may be hard to see due to swollen mucosa, a curved



Fig 1A.



Fig 1B.

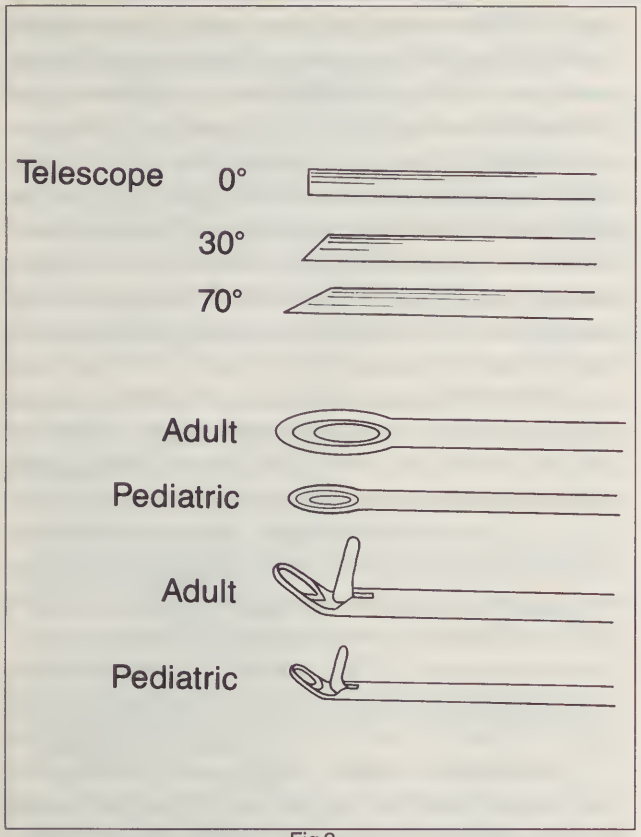


Fig 2.

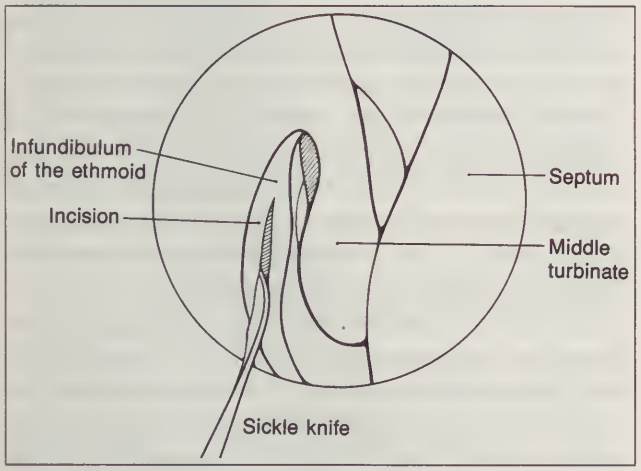


Fig 3.

suction tip was often used to locate the slus. Special back biting forceps were used to enlarge the maxillary sinus ostium anteriorly with care taken to avoid the nasolacrimal duct (Fig.4). Once the maxillary sinus was visualized, any diseased tissue could be removed. Antibiotic ointment was injected into the operative area. Packing was usually not required.

Approximately two weeks after the initial surgery, each child returned to the operating room for followup cleaning of the surgical sites. Although this followup procedure can be done in the office in adults, young

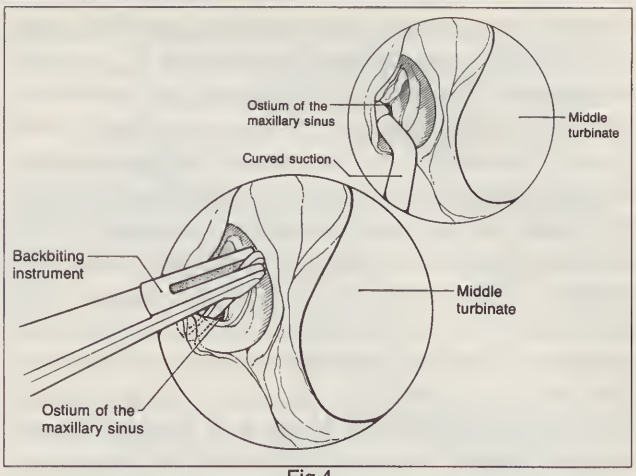


Fig 4.

children require general anesthesia for proper visualization and removal of clots and debris from the surgical sites.

Potential complications from this type surgery are numerous and include bleeding, postoperative infection, damage to the orbit, epiphora, spinal fluid leak, meningitis, and general anesthetic complications None of these problems occurred in this series of patients.

RESULTS

A 17-item questionnaire was completed by the parents of each child. This questionnaire dealt with symptoms of sinusitis, associated medical problems, antibiotic treatment, and number of physician office visits pre and post surgery. The symptoms of sinusitis as noted by the child's parent's were most commonly nasal congestion in 93% of the patients. The next most frequently occurring symptoms were anterior and posterior rhinorrhea followed by nasal sniffles and halitosis. A significant number of children were in a daycare (82%). No attempt was made to quantitate the number of children in each daycare.

Only 35 % of the children had a history which suggested the presence of allergic rhinitis. 81% of the children, however, had undergone allergy testing. Of those tested, 30% of the children were found to be allergic. At the time of surgery 10% of these children were receiving immunotherapy. Antibiotics are the mainstay of medical treatment of sinusitis. Most (79%) of the patients received more than ten weeks of antibiotic therapy in the year prior to surgery. 21% of the children received five to ten weeks of antibiotic therapy. Ancillary treatments included topical intranasal steroids in 46%. Antihistamines and decongestant preparations were employed in 96% of the patients.

The most telling questions dealt with the parent's perception of clinical improvement and would they

choose surgery again versus continued medical treatment. Results were obtained an average of 17.3 months after surgery. To question the frequency and severity of sinusitis plus the response to treatment, a comparison was made of the number of office visits pre and post surgery. Prior to surgery 58% required more than two office visits per month for treatment of sinusitis. Another 33 % of patients were seen 1-2 times per month for treatment of sinusitis. After surgery only 5 % of patients were seen more than twice per month for symptoms relative to sinusitis, while 74% of the patients were seen less than one time per month for treatment of clinical sinusitis. Ninety-three percent of the patients were improved, based on their parents' observations. Indications of improvement included the need for fewer doctor visits, less frequent antibiotics, and a general overall improvement in symptoms. When asked if they would opt for this surgery again, 82% indicated that they would.

Of special interest were those patients with sinusitis which complicated pre-existing asthma. Of the patients treated, 20 had asthma. Asthma was improved in 85% of these patients following surgery. All of these patients were improved in terms of fewer asthma symptoms and need for less medication.

DISCUSSION

Sinusitis in the young child is becoming an increasingly recognized entity. This is due to the heightened awareness by both physicians and the general public of the prevalence of sinusitis. Improved imaging techniques, including particularly the CT scan, have made the diagnosis of sinusitis more precise. The symptoms of sinusitis in the child are multiple. In this study the symptoms were all generalized, including most commonly the complaint of nasal congestion. In contradistinction to adults, complaints of facial pain, headache, or unilateral nasal obstnrction are generally absent.

Functional endoscopic sinus surgery offers a physiologic approach to chronic sinus disease that does not respond to medicaltherapy. Although originally developed for adults, this technique is now being used to treat younger patients. [14,15,16] Medical treatment failures may result despite long term antibiotics and other ancillary treatments such as intranasal steroids, decongestant and antihistamine preparations. All of the patients in this study had received more than a month of antibiotics effective against betalactamase producing bacteria.

Sinusitis often begins as a viral URI. This viral infection causes swelling of the mucosa within the sinuses as well as a paralysis of the cilia within the nose and sinuses. A cascade of events then occurs which results in sinusitis. These events include mucosal edema resulting in altered sinus drainage, stasis of secretions and subsequent bacterial infection. Antibiotics are the mainstay of treatment for bacterial sinusitis. Adequate antibiotic treatment for sinusitis should encompass 3-4 weeks of therapy. Shorter courses of antibiotics do not generally treat the disease and onlv mask the symptoms of this age group.[18] In this study the children received multiple and long courses of antibiotics. The majority (79%) had received more than ten weeks of antibiotic therapy during the year prior to surgery.

Each child had a coronal sinus CT scan that showed maxillary/ethmoid sinusitis with obstructed ostiomeatal complexes before proceeding with surgery. None of these children had any known underlying medical problems such as immunosuppression, cystic fibrosis, or immotile-cilia syndrome nor any anatomic problems such as severely deviated nasal septum, nasal polyps, or hypertrophied turbinates. No major surgical or anesthetic complications occurred at the original or follow-up surgeries.

Ninety-three percent of these young patients were improved based on parenls' assessment on an average of 17.3 months after surgery. Of the various methods of follow-up, the parents' assessment of the child's well being was chosen. In addition to being less expensive than followup CT scans or nasal endoscopy under anesthesia, we felt this method would eliminate any medical observer bias. A questionnaire was mailed to the patients' homes. The vast majority of the patients were improved after endoscopic sinus surgery, and 11% noted that the symntoms resolved completely. Of the 57 patients in the study, 47 indicated that they would be willing to undergo surgery again. An indirect measure of improvement was the number of office visits before and after surgery. Prior to surgery 58% of patients were seen more than twice per month for complaints relative to sinusitis, while 91% of the patients were seen at least 1-2 times per month for treatment. Significant improvement was noted following surgery as only 5% of the children were seen more than twice per month.

Of special interest is the effect of sinusitis on asthma in children. It is recognized that sinusitis may trigger episodes of asthma, making asthma more difficult to manage. Of the patients in this particular study, 35% indicated that they had asthma. Following surgery 85% of these patients were improved and less medication was required for treatment of their asthma.

Although the results of this and other similar studies are encouraging [16,17], many uncertainties remain. Some doctors question the basic need for this procedure in young children [18]. Longer term followup will be required

to determine the safety and effectiveness of FESS. Careful indications should be developed before FESS becomes widely used in this age group[19]. In addition, long-term comparative studies are needed to examine whether FESS offers any advantage to less aggressive management, such as long-term antibiotic suppression and/or simple sinus irrigation. The role, if any, of adenoidectomy also needs to be determined. Finally, in this day of medical cost containment, the financial consequences of sinus disease treatment must also be considered. Even though many question remain, FESS appears to be a safe and apparently effective technique to manage chronic sinusitis even in young children.

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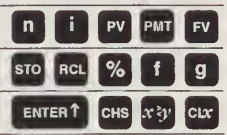
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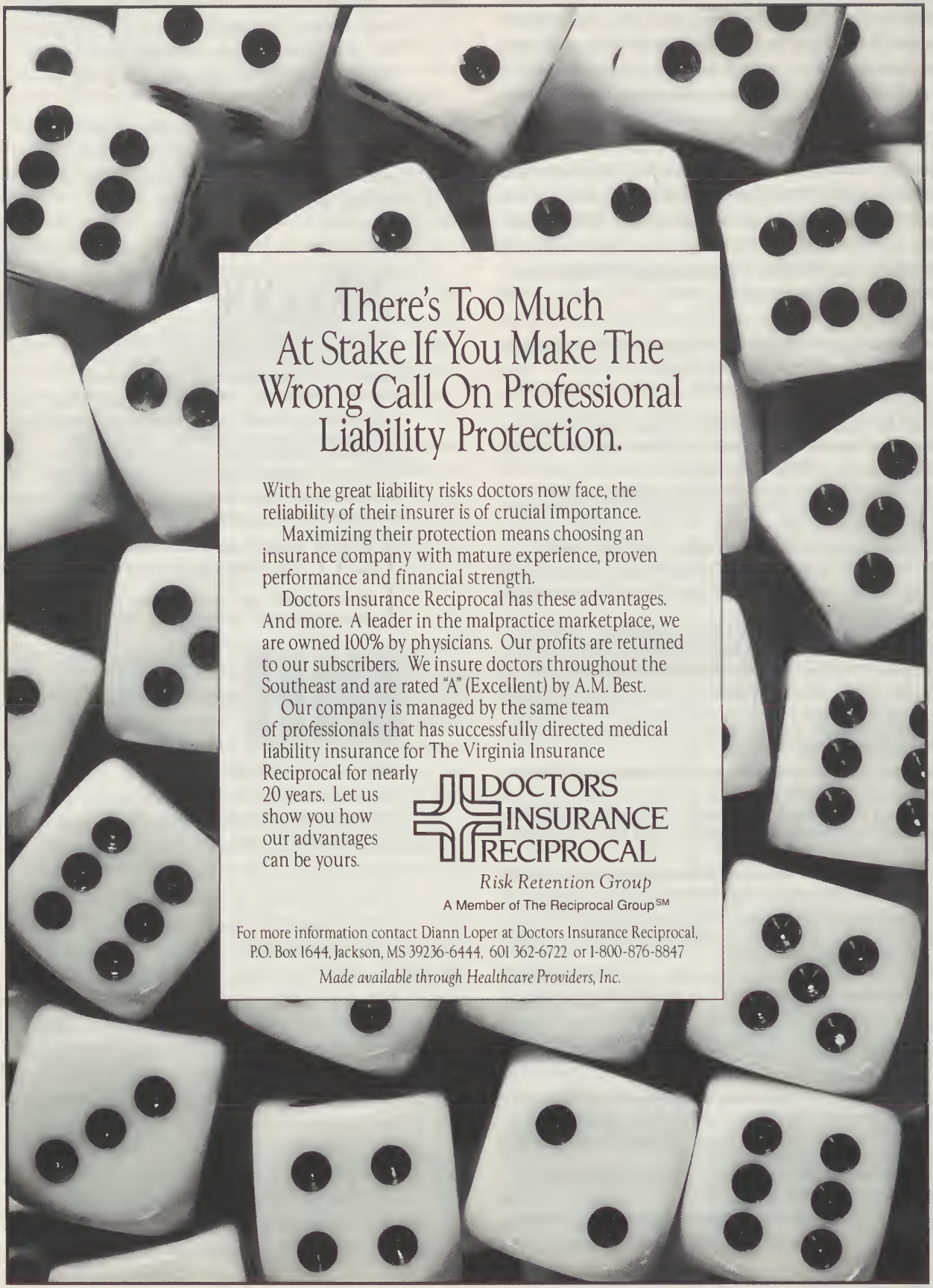
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CLINICOPATHOLOGIC CONFERENCE XXI

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Differential Findings: Lisa A. Vernino, M.D.
Radiological Findings: Mary Frances O'Neal, M.D.
Pathological Findings: Cynthia A. Lynch, M.D.

CASE PRESENTATION

Our case today is about a 49 year old black male who presented to an outside hospital with a chief complaint of abdominal pain for approximately four months. He said his pain was primarily postprandial and associated with biliary vomiting. He also had watery diarrhea, approximately six loose stools a day, for a period of two months or so, but this had resolved prior to his admission there and he had had no bowel movement for the last week prior to admission. He also had approximately a 40 lb. weight loss in the past three months. The patient was admitted to an outside hospital and their impression was that he had an ileus, perhaps associated with diverticulitis. He underwent a course of IV fluids and antibiotics, but his abdominal pain did not resolve. A CT of the abdomen and an upper GI were obtained, which were both consistent with a small bowel obstruction. He was then transferred to the VA Hospital. He gave a review of systems where he denied fever. He also denied night sweats. He said he had a cough that was productive of white sputum and an intermittent red patchy rash on his buttocks, but this was actually resolved prior to this admission. He also had a past medical history of hypertension. He had a tubular villous adenoma removed in 1991, and he had a urethroplasty in 1988. He had a significant tobacco and alcohol history, but he had stopped both of these habits two months prior to his admission, and he had served in the Army in Vietnam for two years in the past.

On his physical exam he was afebrile, had a blood pressure of 100/90, a pulse of 90, and respirations of 12. He weighed 134 lbs., and was 73 inches tall. He was well developed but cachectic and in no apparent distress. His HEENT exam was remarkable for his bitemporal wasting. He had anicteric conjunctivae, and he had dry mucous membranes with no appreciable adenopathy. His cardiovascular exam was unremarkable. His abdomen was soft but diffusely tender and revealed high-pitched bowel sounds. There were no palpable masses or organomegaly appreciated. His rectal exam was unremarkable and heme negative. He had very impressive weeping pedal edema of his lower extremities. His lab showed sodium 131, potassium 3.4, chloride 84, bicarbonate 30, BUN 31, and creatinine 0.8. He had a normal glucose. His protein was 4.3, his albumin of 1.5, and his calcium was 7.9. He had a hemoglobin of 9.9, a hematocrit of 29, and an MCV of 95. His white count was elevated with 60% segs, 14% bands, 8% lymphocytes, 4% monocytes, and 14% eosinophils. His platelets were 553. He later had iron studies with B12 and folate evaluated. He also had IgA, IgG, IgM and IgE levels obtained during that hospitalization, and his IgE level was remarkably high. His urinalysis was negative for proteinuria. He had a nonreactive HIV and a negative PPD. The patient was admitted to the hospital, again, by transfer. He had a KUB obtained and a Gastrografin swallow attempted early in the admission. He had a diagnostic procedure performed. Dr. O'Neal will discuss the radiographs.

Dr. O'Neal: Chest x-ray was obtained on the day of admission and it demonstrated no definite pulmonary infiltrates. In the left lung base, there were a few small, linear densities due to discoid atelectasis or scarring. Supine and erect views of the abdomen were also obtained on the day of admission and demonstrated contrast material in the small bowel. The contrast apparently had been administered at the outside hospital. We did not know when it had been administered. The important findings here were the markedly dilated loops of small bowel which contained air-fluid levels. There was no air or contrast in the colon. It was felt that this pattern was most consistent with a small bowel obstruction. The following day, a repeat abdominal film had essentially the same findings with markedly dilated loops of small bowel, the contrast material in the distal small bowel, and no contrast in the colon. Again it was thought this was a distal small bowel obstruction. Two days later, this pattern of abnormality began to resolve. The small bowel was not quite as dilated and some of the contrast material had passed into the colon. In another two days, the abdominal films were essentially normal. The small bowel was no longer dilated, and there was contrast material throughout the colon.

Dr. Vernino: The patient started out with watery diarrhea. He had hypoalbuminemia that was pretty profound and weight loss. He had an intestinal obstruction,

marked eosinophilia, an elevated IgE, and he had other features of a rash that are not very well described and seemed to have resolved by the time he got here. He also had a cough which may or may not be important. His chest radiograph didn't really show very much, and he had a history of villous adenoma.

I'd like to talk about the diarrhea, of which there are five different types, and the basic pathophysiology of diarrhea. The first type is osmotic where there are poorly absorbable, osmotically active solutes in the intestine. The second type is a secretory diarrhea which has active ion secretion. There is also dysmotility, anything that can cause an altered mucosa, or diarrhea that is just poorly understood. We don't have a lot of information about this patient's diarrhea. We don't have any stool studies that would be helpful, which would have been the first thing I would have done.

Osmotic diarrhea occurs from three different things: ingestion of poorly absorbable solutes (laxatives or sorbitol ingestion), maldigestion (lactase deficiency), or postgastrectomy. Failure of the transfer mechanism can be a cause, also. A feature of osmotic diarrhea is to measure a fecal solute gap, which is obtained by measuring stool osmolality and subtracting two times the stool sodium and potassium. This will be elevated in osmotic diarrhea, and typically the diarrhea stops when the patient fasts.

In a secretory diarrhea, there should be no solute gap and the diarrhea will persist with fasting. A classic example is cholera, but these are other causes: enkrotoxogenic E. coli, carcinoid, medullary carcinoma of the thyroid, pancreatic cholera, VIP-OMA, a pancreatic tumor caused by excess vasoactive intestinal peptide, and gastrinoma. When I first read through the case, I thought these might be a possibility, but they are extremely rare and can cause a rash and diarrhea. As far as I know, they don't cause any eosinophilia or elevated IgE.

Dysmotility can be caused from infections or bacterial overgrowth, intestinal hurry, or premature emptying of the colon. Examples are irritable bowel syndrome, incontinence, thyroid disease, or other infections.

Anything that alters the intestinal mucosa can cause diarrhea, and this may be what is going on in this patient. Viral gastroenteritis, sprue, radiation enteritis, or lupus can be causes. Other entities that might be more likely in this patient include inflammatory bowel disease, lymphoma, eosinophilic gastritis, and amyloidosis.

As I mentioned, stool electrolytes and fecal solute gap may be helpful to try to classify the type of diarrhea. If there is stool for white cells in an occult blood test, that can be a clue as to whether there is any inflammation present. A fat stain can tell you whether a bowel obstruction might be present. If you suspect the patient is ingesting laxatives, alkalinization of a stool sample can tell you whether phentetiothalein is present. I would have looked for infectious organisms and parasites with this patient. Sigmoidoscopy and rectal biopsy may also help in selected cases.

Another feature that this patient had was hypoalbuminemia, and we are not really given much information about whether he might have liver disease. His liver enzymes were normal and there is nothing in the case that would suggest that liver disease is the etiology of his hyperalbuminemia. His urinalysis was basically normal and he did not have a lot of protein, so I think we can rule out renal disease as a cause of hypoalbuminemia. We are left with GI problems, either malnutrition or protein gastroenteropathy as the cause, and he may have a combination of these. Causes of protein gastroenteropathy, which can be divided into either lymphatic obstruction or mucosal disease, include lymphatic obstruction, Crohn's disease, or Whipple's. Lymphoma can also cause mucosal disease, inflammatory bowel disease, Crohn's, ulcerative colitis, carcinoid syndrome, celiac disease, or intestinal parasites. Eosinophilic gastroenteritis is also a consideration as well.

Dr. O'Neal had talked about the patient having a distal small bowel obstruction. Early on, the patient's pain sounded more like proximal small obstruction. His abdominal pains were intermittent, and he had bilious vomiting and periumbilical pain, as opposed to a distal small bowel obstruction where there is more vomiting and more marked distention and diffuse tenderness.

One of the interesting features that the patient had was eosinophilia, and allergic diseases are one of the causes of eosinophilia. Cutaneous diseases, such as pemphigoid, herpes, or other immunologic skin diseases can cause eosinophilia. We don't have any indication that's going on with this patient. Other causes include pulmonary diseases, such as Loffler's syndrome, aspergillosis, or eosinophilic pneumonia. He really didn't have a lot of prominent pulmonary features, so I don't think that would be a high consideration. Connective tissue diseases can sometimes cause eosinophilia and vasculitis, such as Churg-Strauss, and the history doesn't really give us any features of that. Scleroderma can cause eosinophilia. I think that would be a very low possibility, although there can be systemic sclerosis without skin features, but it is very rare. Hypersensitivity vasculitis and rheumatoid arthritis may also cause eosinophilia, but he really doesn't have any features of either of these. Immunodeficiency, hyper-IgE syndrome, selective IgA deficiency and Addison's disease would be low on the list of etiologies.

Other diseases that can cause eosinophilia and would be considered much more strongly in this patient include: myeloproliferative diseases, solid tumors, especially mucin-secreting tumors, lymphoma, ALL, myeloma, eosinophilic leukemia, and hypereosinophilic syndrome. Infectious diseases, such as TB, may cause eosinophilia. Even though his PPD was negative, tuberculosis is not ruled out. Lung diseases and parasitic infections are very high possibilities and there are a few that would be more likely to be seen on this continent (Ascaris, Strongyloides). Also on the list are GI diseases, such as eosinophilic gastroenteritis (GI symptoms associated with infiltration of the bowel with eosinophils not associated with any other organ systems being infiltrated). Inflammatory bowel disease can also cause eosinophilia.

Typically, one would think of allergic diseases causing IgE, but causes also include parasitic diseases, other infections, some of the cutaneous diseases that we have already mentioned, and neoplastic diseases. The main diseases that would be looked at would be parasitic diseases and eosinophilic gastroenteritis which can also cause elevated IgE.

The most likely diseases in this patient are lymphoma, TB, and inflammatory bowel. I think either parasitic infection or eosinophilic gastroenteritis (or hypereosinophilic syndrome) would be the two diseases that I would consider the most likely. I would do stool studies if they could be obtained from the patient and upper endoscopy, along with aspirate and biopsy.

Dr. Lynch: An upper endoscopy was performed and very edematous folds in the small bowel were found that were causing the mechanical obstruction. Biopsies were obtained that showed organisms, many cut in cross section within the crypts. One can also appreciate that the lamina propria of the small bowel does not have an eosinophilic infiltrate, which is a little unusual, but there are many plasma cells and lymphocytes. This was Strongyloides stercoralis with many rhabditiform larvae. Several cross sections of an adult female were identified. The luminal mucus was full of eggs and larvae worms. This patient had a hyper-infection with Strongyloides stercoralis. He also had Strongyloides identified in his sputum. We did not receive a stool specimen on this patient, but I am sure it would have been positive. In the stool very rarely would you find the ova of Strongyloides. The eggs usually hatch in the intestine and thus auto infect the host. In the stool specimens, the larvae have to be separated from hookworms which is done of the basis on the length of their pharynx and also their tail since both parasites are about the same size. An interesting finding with Strongyloidosis is that if the sputum is plated and the worms are present, they will crawl across the plate. As they crawl across the plate they will drag the bacteria with them. This is one reason that people with Strongyloides can develop an E coli meningitis because the worms, as they migrate through the body, may take bacteria with them. The geographic distribution of Strongyloides is worldwide. It is endemic in the southeastern United States. The highest prevalence rate is about 4% in Kentucky and rural Tennessee and obviously it is here in Mississippi. The patient was from Ethel, up the Natchez Trace near Kosciusko. The primary infection starts when the filariform larvae in the soil penetrate through the skin and enter the cutaneous blood vessels and travel to the alveoli of the lungs breaking through the capillary bed. They are then coughed up and swallowed. The larvae enter the mucosa of the small intestine and develop into the adult. They will lay eggs which will hatch within the intestines and reinfect (auto infect). They also can reinfect through the perianal skin and that is where (auto infection) rashes sometimes appear as the filariform larvae begin migration. The buttock rash of the patient may have been the re-infestation. With most parasites, the worm burden is determined by how many worms you have been exposed to through the skin. With this parasite, the worm burden, especially in an immunocompromised host, can become extremely heavy because of auto infection. And indeed, this man had a heavy worm burden as evidenced by the biopsy. Strongyloides infection may be asymptomatic. People have it, and it becomes manifest when they are immunosuppressed. The usual symptoms are related to the intestine: diarrhea, intermittent constipation, abdominal pain, nausea and vomiting. Obstruction like this patient had is not usual.

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***Dr. Files** is Professor of Medicine and Associate Chairman, Department of Medicine. **Dr. Vernino** is Assistant Professor of Medicine. **Dr. O'Neal** was Assistant Professor in the Department of Radiology. **Dr. Lynch** is Assistant Professor in the Department of Pathology.*

***Drs. Robbins, Stewart,** and **Wofford** were Chief Medicine Residents in the Department of Medicine at the University Medical Center in 1996-1997.*

Coding Concepts

Q. As a nurse practitioner, I often serve as the primary assistant for my surgeon in the hospital operating room. To receive payment for my services, the office applies modifier -81, Minimal Assistant Surgeon, to the surgical codes. Is this the correct modifier to report my services? Other offices have stated that we should be using Modifier -80 to report my surgical assistant services.

A. From a CPT coding stand point, it would be inappropriate to use either one of these codes to report your services. According to CPT, the modifiers are to be used to report the services of another physician providing a surgical assist.

However, many third party payers may allow an office to use these modifiers for other than non physician personnel providing assistant surgical services.

To be in compliance with the coding rules, your office should check with the individual carriers with whom you have contract agreements to determine their rules for using these modifiers for non physician providers of services.

According to a HCFA spokesperson, there is no coverage for a nurse practitioner or clinical nurse specialist acting as a surgical assistant. You may find this to also be the case with most commercial carriers. According to HCFA guidelines, the following services are covered for Clinical Nurse Specialists and Nurse Practitioners.

CLINICAL NURSE SPECIALIST	NURSE PRACTITIONER
● Physical evaluations	● Physical evaluations
● Cast applications for simple fractures	● Cast applications for simple fractures
● Minor surgery	
● X-ray interpretation	

For physician assistants, Medicare has established a specific modifier to report their services in the operating room.

-AS Physician assistant services for other than an assistant-at-surgery, non team member.

The AMA's definition and intended use of Modifiers -80 and -81.

Modifier -80, Assistant surgeon may be used to report the services of another physician assisting a primary surgeon provided the assistant was present for the **entire** operation or a substantial portion of the operation. According to the AMA, each physician would have an operative report to indicate the distinct service provided by each surgeon.

Modifier -81, Minimum assistant surgeon, would be used when the primary surgeon had planned to perform the procedure alone, but due to circumstances that may arise in the course of the procedure, the surgeon requires an assistant for a relatively short time.

For physicians in teaching facilities, **Modifier -82, assistant surgeon** has special emphasis. The prerequisite for this modifier is that a qualified resident surgeon is unavailable to provide the assist. Modifier -82 indicates another surgeon is assisting with the operation instead of a qualified resident surgeon.

CODING TIP

For correct coding, an office should have a clear understanding of CPT coding guidelines as well as third party payer rules. Investigate your contract agreements for non physicians provider coverage to avoid fines and penalties.

Do you have a question you would like answered in the Journal? Send your inquires to Wanda L. Adams, CPC, Adams & Associates, 3201 Cambridge Drive, Festus, MO 63028. Please include your name and phone number should additional information be required.

Wanda L. Adams, CPC, is owner and president of Adams & Associates, a health care consulting firm. She is a senior health care consultant and published author. She currently serves on the National Advisory Board of the AAPC and the Editorial Panel of Code Facts, a Medicode publication.

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"The Speed of the Leader Determines the Rate of the Pack."

Michael H. Carter, Jr., M.D.

The President's Page

Physicians are natural leaders. Doctors are trained to analyze symptoms, identify diseases, recommend treatments and predict prognoses. They are very bright (most passed physics and some discovered vaccines or patented sophisticated technologies). Most are extremely talented. But the ones that are most successful are also the ones who had a cherished teacher — a mentor, friend or colleague who was an inspiration.

I want to be like that. I want to inspire a young doctor to push past managed care to discover the exhilaration I feel when a patient recovers. I'm not sure I know what it takes to be that kind of muse. A study comparing the personality profiles of positive role models in medicine provided insight.

The study published in ***Psychological Reports*** identified five factors and 30 facets of personality exhibited by physicians nominated as positive role models in medicine.

There's no doubt that personal qualities play an important role in all aspects of an individual's life, including professional success. But I didn't think it would be so easy to pigeonhole physicians.

Not surprisingly, both male and female physician role models scored significantly higher than the population norms on the Conscientiousness factor indicating "that these physicians tend to be more rational, prudent, purposeful and strong-willed and are also likely to be more scrupulous, punctual and reliable." Female physicians were found to have much larger differences from the population norm than did males. Female physician role models peaked on the Extroversion factor indicating they are likely to be "more active, talkative, warm and affectionate than the general population of women." They often reported strong feelings of joy and happiness. They also seemed to be more receptive to their own emotions, be more appreciative of art and beauty and be more cheerful and optimistic.

Male doctors scored higher on agreeableness factors which the authors suggest to mean they are cooperative and eager to help. They were found to adhere more strictly to their ethical principles and moral obligations than the population norms. Physicians of both genders were found to have high aspirations and be especially hard-working, prudent, effective and in control. It was most interesting that the physician role models were inclined to believe that others are honest and well-intentioned.

So what does it take to be an inspiration, a muse, a mentor? I think it first takes a moment of self-reflection (Remember the exhilaration of dissecting your first cadaver?). And how does a physician become a mentor? A good place to start is by sharing the enthusiasm for science and learning and life that medicine has entrusted in us physicians.

Mike Carter

Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XXXIX, NUMBER 12
DECEMBER 1998

Wishful Thinking

Deck the halls with patients, charts... Fa-la-la-la-la-la-la-la-la ... 'Tis the season for brave hearts... Fa-la-la-etc...

The pace of the holidays seems to become even more hectic for the medical profession: Patients who have met their deductibles demanding appointments for routine physicals during a time when your office is down to a skeleton crew; partners who hunt jockeying for time off to lay by the game du jour lest their families starve during the harsh winter; patients who have required hospitalization for life-threatening illnesses becoming indignant at the prospect of not being fully recovered by Christmas eve.

Spirit-dampening scenarios such as these give new meaning to the term "Christmas wish list". If the opportunity to make such a list (while checking it twice) ever presents itself, the following requests will be near the top:

1. Ban of "co-promotion" of drugs by pharmaceutical reps.

2. Revitalization of MSMA component societies.

3. Moratorium on Viagra jokes.

4. Standardization of forms by the pharmaceutical industry for requesting medicine for indigent patients.

5. Construction of a Habitat for Humanity home from recycled junk mail.

6. Moratorium on Monica Lewinsky/Bill Clinton jokes.

7. Ability of physicians, patients, and their families to deal rationally with End-of-Life issues.

8. Revocation of onerous government and third party red tape/regulations.

9. Acknowledgment by insurance companies that a patient's status is better assessed by an attending physician standing by the bedside rather than by a nurse calling from Kalamazoo.

10. Adoption of healthful lifestyles by our patients with the hopes that they're not run down by a 400-pound drunk driving a cigarette truck.

Not wishing to push my luck with the usually accommodating jolly, old elf with any further farfetched requests and with apologies to Dave Letterman and his Top Ten list, I simply wish you and yours a joyous holiday season and a prosperous new year.

—Stanley Hartness, M.D.
Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

A Fight Over Privileges

It is that time again in Natchez, this small town of some fifty doctors. We are having that bloodiest of all businesses, a hospital privileges fight. Oh, it is something. There are hearings and ad hoc committees and attorneys, tape recorders, charges, counter charges, gnashing teeth and righteous tableslapping indignation. Somewhere amid the rubble lies the truth, often startlingly simple, even considering the legal smokescreens.

I wish, though, that those who say we fail to police our profession could see some of this. There is something about the sight of doctors devoting their valuable time to insuring adherenceto peer determined privileges that makes one proud. Legal risks and jangled nerves aside, it is an absolutely necessary process if we're to maintain the integrity of our profession.

The opinion has been expressed that as managed care becomes more predominant businessmen will effectively be making the credentialing decisions. Let us have none of it. As doctors this is our business, and we will rue the day when we can no longer go to the mat on these matters. Dust clouds from these battles still sprout over Mississippi. We must be thankful even as we file into the hearing rooms and the tape recorders are turned on.

—Leslie E. England M.D., Editor



Photo by Gregory Heisler

Charmain Thompson, Deputy Director and Director of Government Affairs



Years with company: Four

Previous position: Director of Government Affairs

Business philosophy:
"What goes around comes around."

Favorite quote:
This is a hard question to answer simply. I've always been fascinated by language and the way words are used together to provoke an image or concept previously beyond reach. Some of my favorites follow. "The sweeter the apple the blacker the core." Dorothy Parker; "He who can lick can bite." French proverb; "It doesn't matter if a cat is black or white so long as it catches mice." Deng Xiaoping; "I done licked that calf." State Rep. Billy McCoy; "The best way to clean a skillet is to make gravy." Some other Sutherner. Finally, I would be pleased as punch if someone would see fit to put the following scripture from Mark 14:8 on my tombstone. It pretty well sums up what I hope to live up to. "She hath done what she could."

Favorite books:
"Lawyers and Other Reptiles;" ***"All Politics is Local"*** by Tip O'Neill; ***"Confessions of an S.O.B."*** by Al Neuharth; ***"Weird Words"*** by Irwin M. Berent; ***"The Collected Writings of Dorothy Parker;"*** ***"The Seersucker Whipsaw"*** and ***"The Fourth Durango"*** by Ross Thomas; ***"The Language of Life"*** by Bill Moyers; and ***"The Essential Rumi"*** translated by Coleman Barks.

Recently read:
"Divine Secrets of the Ya Ya Sisterhood," by Rebecca Wells; ***"Point of Origin,"*** by Patricia Cornwell; and ***"She's Come Undone,"*** by Wally Lamb.

Hobbies:
Buy and selling antiques, going to antique auctions and estate sales, gardening, reading and writing poetry.

Hometown:
I was born in Heidelberg, Germany while my father was in the Army. We returned to the States when I was three and settled in what I call my hometown, Monette, Arkansas. It was there I learned to drive a Studebaker pickup truck with four-in-the-floor, make darn good cat-head biscuits and that it was time to leave.

Dreams:
I've always wanted to be able to paint really great impressionistic landscapes that have purple and red skylines.

Most valued virtue: Loyalty.

Heroes:
The first person to ever drink cow's milk. Whoever invented the martini. Will Rogers because he was so clever and eloquent.

Key formative experiences:
My father died in 1984 but for as far back as I can remember, Daddy took me duck hunting on Thanksgiving Day. After a toe-numbing, 6-mile ride in a flat bottom boat down an icy slough at 4:00 a.m., we spent the rest of the day in a cozy duck blind waiting for dawn, frying catfish, playing poker and talking about important stuff like fishing bait and boyfriends. The year I was 7 I learned that I preferred my coffee black. The year I was 14 I decided it was okay to break up with Ricky Phillips. When I was 17 I learned that Daddys' hugs can cure the homesickness you get when you go away to college. And, the year I was 20 I realized that, although unlikely, there was a remote possibility that Daddy did know a better way for me to pick boyfriends.

Family:
It's just me and Max, a bob-tailed Siamese cat, and his cat, Sasha.

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Mark Sherer, Ph.D., ABPP
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Stuart A. Yablon, M.D.
MMRC Brain Injury Program Director



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Annual Health Plan Process Begins

The Mississippi State Department of Health develops a State Health Plan each year under the authority of Section 41-7-173(s) and Section 41-7-185(g), Mississippi Code 1972 Annotated, as amended. The State Health Plan has three purposes: (1) to identify priority health needs in Mississippi;- (2) to recommend ways in which those needs can be met; and (3) to establish criteria and standards for health related activities which require Certificate of Need review. The Department includes public comment from the beginning of the development process through final adoption of the revised Plan.

The process begins each fall with a public forum generally held before the State Board of Health at the Board's October meeting. At this forum, any concerned individual has an opportunity to make suggestions regarding any aspect of the Plan or propose changes to Certificate of Need (CON) criteria and standards. Anyone unable to attend the forum may submit written comments by mail. Staff of the Division of Health Planning and Resource Development study the comments and develop recommendations for any needed changes in CON criteria and standards.

Each January, staff requests the Board of Health to approve an "intent to adopt" the proposed revisions and

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files the proposal with the Secretary of State. This action initiates a 30-day public comment period in accordance with Mississippi's Administrative Procedures Act.

The Department publishes proposed changes in a statewide newspaper, *The Clarion-Ledger*, mails a copy of all proposed changes to an established list of interested parties, and publishes the proposed changes in a monthly Department newsletter sent to more than 1,000 health care facilities, individuals, and organizations. The Department also provides the proposed changes to anyone who requests a copy.

Staff analyzes any comments received and incorporates them into proposed changes wherever possible. Staff presents final recommendations to the Board of Health at the April Board meeting each year. The Board approves or disapproves each proposed change and issues a "final adoption" of the revised Plan. The Department files the Plan as adopted with the Secretary of State.

Staff also obtains up to date statistical and general information from numerous departments of the MSDH, other state agencies, professional associations, and relevant organizations regarding every topic covered in the Plan. Staff compiles this information and produces a final Plan. Following approval by the Governor, the revised Plan becomes effective July 1 of each year.

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IQH Establishes A Foundation for Funding Collaborative Health Care Quality Improvement Initiatives

The establishment of a foundation for funding collaborative health care quality improvement initiatives was announced recently by I.Q.H. The official kickoff of the new foundation coincided with the observation of National Health Care Quality Week Oct. 26-31.

The "I.Q.H. Foundation" will enable tax-deductible donations made by individuals, groups, and organizations to support quality initiatives and also allow non-profit healthcare organizations seeking funding for quality improvement projects to apply for grant consideration.

Serving as a medical peer review organization in the state for 27 years under the name of Mississippi Foundation for Medical Care, I.Q.H.'s name change earlier this year reflects its new emphasis on quality improvement through collaboration. I.Q.H. stands for the best quality of care for all our citizens, and through this innovative foundation, I.Q.H. can better realize its vision for the future of quality health care in the state. Prevention and education are key components.

Individuals, groups, and organizations can be a part of the effort through tax-deductible donations to be funneled back to the community through health care quality improvement projects. In the future, non-profit healthcare organizations seeking funding for quality improvement projects which fall within the I.Q.H. mission may make grant applications for consideration by an I.Q.H. Foundation advisory council.

A Commitment to Quality Celebration began the 'Founding Patrons' campaign in November.

Further information is available through Denise Auttonberry, Ph.D., RN,C, CNAA, CHE, who serves as vice president for corporate services and who is assuming the additional role of executive director for the Foundation.

I.Q.H. has received funding from the Cooperative Actions for Health Program (CAHP), a collaborative grant program co-sponsored by the American Medical Association and the American Public Health Association with support from the Robert Wood Johnson Foundation.

The special grant will be for building, supporting, and strengthening state and local collaboration between medical and public health professionals to improve the public's health.

Covering a period of a year, the grant will address the concern shared by medicine and public health professionals about the overall future of the American healthcare system. The system's ability to adapt to the changes in disease patterns, demographics, and resource availability is vital to the continuing improvement of the health of all citizens in the state.

—James S. McIlwain, M.D., President

Cameron Recognized for 30 Years Service to Mississippi Hospital Association

Sam W. Cameron has been recognized by the Mississippi Hospital Association Board of Governors for 30 years of service to the Association.

Dan Harrison, MHA chairman and senior vice president, Rush Foundation Hospital, Meridian, presented a plaque and resolution from the Board to Cameron recently at the annual MHA Membership Luncheon during the Association's 67th Annual. Leadership Conference.

Cameron, a native of Hattiesburg, began employment with MHA in 1969 as staff assistant to the executive vice president, and in 1980, he was named president/CEO of the Association.

Prior to employment with the Association, he served as business manager-administrative assistant at Methodist Hospital in Hattiesburg (now Wesley Medical Center). He holds a bachelor of arts degree in business administration-personnel administration from the University of Southern Mississippi, Hattiesburg, and an associate degree in personnel administration from Pearl River Junior College (now Pearl River Community College), Poplarville.

Under Cameron's leadership, MHA, formed in 1931, promotes and protects the interests of its member hospitals and health systems and their 50,000 employees, which includes all 116 hospitals in the state.

Cameron is a charter member and former president of the Mississippi Society of Association Executives (MSAE) and initiated the establishment of the organization. He has also served on the cabinet of the United Way, is a past member of the Rotary Club and is a member and past president of SHAEF (State Hospital Association Executives Forum).



Sam W. Cameron**, right, was recognized recently by the Mississippi Hospital Association Board of Governors for three decades of service to the Association. Dan Harrison, MHA chairman, presented a plaque and resolution from the Board to Cameron during the Association's 67th Annual Leadership Conference. Pictured with Cameron is **his wife, Bonnie.

Placement Service

Journal MSMA Placement ads are $2.50/line, with a 5-line minimum charge of $12.50. There are approximately 50-characters per line in 11 point Times Roman type; including each letter, space and all punctuation. Ad copy must be submitted in writing. Items should be sent to: **Placement Service, Journal MSMA, P.O. Box 5229, Jackson, MS, 39296-5229, or Fax to: 601/352-4834**

Journal MSMA Display Classified ads 1x insertion cost $115.00 per 1/4 page block (3 1/8 x 4 3/8 vertical or 6 1/2 x 2 1/8 horizontal). Camera-ready materials are preferred. Typeset ads are available for an additional charge. Items should be sent to:**Classified Section, Journal MSMA, P.O. Box 5229, Jackson, MS, 39296-5229, or Fax to: 601/352-4834**

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Disability Determination Services
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CLINICAL DIRECTOR

North Mississippi State Hospital (NMSH) is currently accepting applications for a board certified psychiatrist to serve as clinical director. NMSH will open this winter as a 50-bed acute psychiatric hospital in Tupelo. Clinical Director will be an integral part of hospital leadership and responsible for interdisciplinary treatment programming in a values-based quality environment. Excellent benefits and a competitive salary. Interested candidates should send their resume to:

North Mississippi State Hospital
P.O. Box 86, Whitfield, MS 39193
For more information contact:
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The Mississippi State Department of Health is seeking qualified candidates for the position of Physician, Senior, Office Director for the Office of Personal Health Services, in Jackson, MS. This position is responsible for the following areas: • Directing an office within the State Department of Health that has approximately 200 employees and an operating budget of approximately $57 million. • Planning, conducting, and supervising through subordinate staff, programs aimed at improving the health status of women, infants, and children throughout the state (maternal-child health, family planning, child health, children with special health care needs, and WIC). • Rendering consultative services in maternal-child health matters to public officials, voluntary health agencies, committees, other professional health care providers, and various other health care organizations. • Utilizing epidemiological and other surveillance methodologies in planning public health initiatives and consultation, in preparing reports, and in making public presentations.

Salary Range: $90,310-$115,000 annual

Minimum Requirements: Licensed to practice medicine in Mississippi, Experience in public health and/or maternal-child health, Masters in Public Health preferred but not required.

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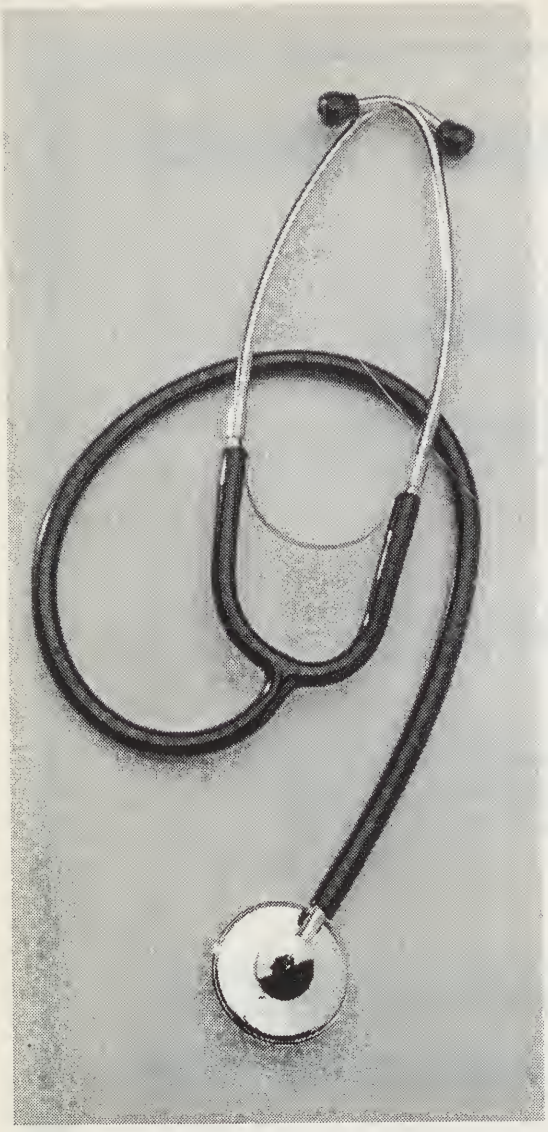
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